Dr. El-fellani MOHAMMED

Discipline Hearing Committee Decision

Date Charge(s) Laid:	June 17, 2017
Date of Discipline Hearing:	September 17, 18 and 19, 2018
Date of Decision:	July 31, 2019
Date of Penalty Hearing:	September 13, 2019

This matter proceeded to hearing before the Discipline Hearing Committee. The decision of that committee is attached.

IN THE MATTER OF
THE MEDICAL PROFESSION ACT, 1981, R.S.S. 1980-81, C. M-10.1, AND

DR. El-FELANNI MOHAMMED, OF THE CITY OF REGINA, IN THE PROVINCE OF SASKATCHEWAN

HEARING OF THE DISCIPLINARY HEARING COMMITTEE
OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF SASKATCHEWAN

Date of Hearing: September 17, 18 and 19, 2018

Date of Decision: July 31, 2019

Before: Daniel Shapiro, Q.C
Dr. Dimitri Louvish
Dr. Lorne Rabuka

Counsel: Sheila Torrance and Bryan Salte, Q.C.
(for the College of Physicians and Surgeons of Saskatchewan)

Nicholas Cann, Q.C. and Katherine Melnychuk
(for Dr. Mohammed)

DECISION

A. SUMMARY

[1] Two patients complained that during office visits with Dr. El-fellani Mohammed, endocrinologist, they were subjected to inappropriate touching and behavior by Dr. Mohammed. The issues before the hearing committee were decided as follows:

(a) Ought a Family Medicine physician to be permitted to give opinion evidence on the standards applicable to an endocrinologist in conducting a physical examination, including a stethoscope examination, as well as ethical and communication standards?

Answer: Yes, with qualifications.

(b) Should the Committee consider the complainants' subjective evidence about their own responses to their interactions with the physician?

Answer: Yes, with qualifications.

(c) Should the Committee consider the evidence of individuals to whom the complainants reported their experiences with the physician soon after their last appointments with him?

Answer: Yes, with qualifications.

(d) Should the Committee consider similar fact evidence tendered by the College?

Answer: The Committee should not consider the evidence of the non-

complainant patient but should consider inter-charge evidence provided by the complainants, with qualifications."

(e) How should the Committee assess and weigh conflicting expert evidence led by the parties?

Answer: The Committee gives considerable weight to the testimony of the expert witness tendered by the College of Physicians and Surgeons of Saskatchewan ("the College"). The Committee accepts the testimony of the expert witness tendered by Dr. Mohammed insofar as it relates to whether certain physical examinations were medically necessary as part of a thyroid examination. Apart from this, the Committee gives little weight to the testimony of this witness.

(f) What standard of proof applies?

Answer: The standard of proof set out in McDougall, infra, applies: the evidence must always be clear, convincing, and cogent in order to satisfy the balance of probabilities test."

(g) Has the College") has met that standard?

Answer: The College has met the burden of proving the essential elements of the charges under the Medical Profession Act, 1981.

B. CHARGES

[2] The Council for the College directed that the Discipline Hearing Committee hear and determine the following charges laid against Dr. El-fellani Mohammed:

1. You Dr. El-fellani Mohammed are guilty of unbecoming, improper, unprofessional, or discreditable conduct contrary to the provisions of Section 46(o) and/or Section 46(p) of The Medical Profession Act, 1981, S.S. 1980-81, c. M-10.1, and/or bylaw 8.1(b)(ix) and/or bylaw 8.1(b) (xvi) of the bylaws of the College of Physicians and Surgeons.

The evidence that will be led in support of this charge will include some or all of the following:

1) A female person hereinafter referred to in this charge as Patient #1 was your patient;
2) On or about the 19th day of July, 2016, Patient #1 attended upon you;
3) On or about July 19, 2016 you placed your hand, with a stethoscope, down the front of Patient #1's shirt;
4) You placed the stethoscope on or in close proximity to Patient #1's breast;
5) You asked Patient #1 to lean forward while you were standing in front of her;
6) On or about August 18, 2016 you advised Patient #1 that you would conduct a thyroid examination on her;
7) While conducting that examination you brushed Patient #1's hair from her neck;
8) On or about August 18, 2016 you conducted a stethoscope examination without an appropriate medical justification;
9) You placed your hand, with a stethoscope, down the front of Patient #1's shirt;
10) You placed the stethoscope on or in close proximity to Patient #1's breast;
11) You asked Patient #1 to lean forward while you were standing in front of her;
12) On or about August 18, 2016 after your examination of Patient #1, you stood in front of the door to the room with your foot against the door;

13) On or about August 18, 2016 after your examination of Patient #1, you placed your arm around her lower back and hip;

14) On or about August 18, 2016 after your examination of Patient #1, you placed your hand on her buttocks;

15) On or about August 18, 2016, after your examination of Patient #1, you looked at her buttocks.

2. [Amended] You Dr. El-fellani Mohammed are guilty of unbecoming, improper, unprofessional, or discreditable conduct contrary to the provisions of Section 46(o) and/or Section 46(p) of The Medical Profession Act, 1981, S.S. 1980-81, c. M-10.1, and/or bylaw 8.1(b)(ix) and/or bylaw 8.1(b) (xvi) of the bylaws of the College of Physicians and Surgeons.

The evidence that will be led in support of this charge will include some or all of the following:

1) A female person hereinafter referred to in this charge as Patient #2 was your patient;

2) On or about the 4th day of August, 2016, Patient #2 attended upon you;

3) On or about the 4th day of August, 2016, you repeatedly touched Patient #2's forearm and shoulder;

4) On or about the 4th day of August, 2016, you placed your hand on her right shin;

5) On or about the 4th day of August, 2016, you inserted your stethoscope under Patient #2's dress from the top of that dress;

6) You placed the stethoscope on Patient #2's breast;

7) On or about August 4, 2016 you touched Patient #2 frequently, or in inappropriate places and/or for extended times;

8) On or about August 4, 2016 you engaged in inappropriate personal conversation with Patient #2 including asking her about her vacations and her work;

9) On or about August 4, 2016 you asked Patient #2 if you could visit her at work;

10) You inappropriately and unnecessarily touched Patient #2 on visits prior to August 4, 2016.

C. RELEVANT STATUTORY PROVISIONS AND BYLAWS

[3] The directly relevant sections of the *Medical Profession Act, 1981* ("the Act") provide:

> 46. Without restricting the generality of "unbecoming, improper, unprofessional or discreditable conduct", a person whose name is entered on a register is guilty of unbecoming, improper, unprofessional or discreditable conduct if he or she:
>
> …
>
> (o) does or fails to do any act or thing where the discipline hearing committee considers that action or failure to be unbecoming, improper, unprofessional or discreditable;
>
> (p) does or fails to do any act or thing where the council has, by bylaw, defined that act or failure to be unbecoming, improper, unprofessional or discreditable.

[4] Section 6(2)(m) of the Act authorizes Council to enact bylaws that define professional misconduct. Pursuant to that section of the Act, Council enacted a Code of Ethics, Unprofessional Conduct, Discipline, and Competency Assessments, including the following:

> **8.1 Bylaws Defining Unbecoming, Improper, Unprofessional or Discreditable Conduct**
>
> (a) In this section:

(i) "standard of practice of the profession" means the usually and generally accepted standards of practice expected in the branches of medicine in which the physician is practicing;

(ii) "Sexual impropriety" and "sexual violation" include, but are not limited to:

1. Acts or behaviours which are seductive or sexually-demeaning to a patient or which reflect a lack of respect for the patient's privacy, such as examining a patient in the presence of third parties without the patient's consent or sexual comments about a patient's body or underclothing;

2. Making sexualized or sexually-demeaning comments to a patient;

3. Requesting details of sexual history or sexual likes or dislikes when not clinically indicated;

4. Making a request to date a patient or dating a patient;

5. Initiation by the physician of conversation regarding the sexual problems, preferences or fantasies of a patient;

6. Kissing of a sexual nature with a patient;

7. Physician-patient sex whether initiated by the patient or not;

8. Conduct with a patient which is sexual or may reasonably be interpreted as sexual such as touching any sexualized body part of a patient except for the purpose of an appropriate examination or treatment;

9. Touching any sexualized body part of the patient where the patients has refused or withdrawn consent;

10. Sexual acts by the physician in the presence of the patient.

(b) The following acts or failures are defined to be unbecoming, improper, unprofessional or discreditable conduct for the purpose of Section 46(p) of the Act. The enumeration of this conduct does not limit the ability of Discipline Hearing Committees to determine that conduct of a physician is unbecoming, improper, unprofessional or discreditable pursuant to Section 46(o):

…

(ix) Failing to maintain the standard of practice of the profession;

…

(xvi) Committing an act of sexual impropriety with a patient or an act of sexual violation of a patient.

…

[5] It is left to the medical profession to determine what constitutes unprofessional conduct[1] and in so doing, a committee is entitled to use its medical knowledge and expertise.[2]

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[1] *Green v CPSS* 1986 CanLII 3238 (SK CA) 51 Sask. R. 241 at 246

[2] *Huerto v CPSS*, 2004 SKQB 360 (CanLII) [2004] S.J. No. 550 (Smith J.)

D. BURDEN OF PROOF

[6] The parties agree, and it is beyond dispute, that the burden of proof in disciplinary proceedings such as these lies squarely upon the College.

E. STANDARD OF PROOF

[7] It is common ground that the standard of proof that applies in this case is the "balance of probabilities." The parties disagree as to what that means in a case such as this where the charges are very serious.

[8] Dr. Mohammed's counsel cites judicial authorities to the effect that there may be degrees of probability within the balance of probabilities standard, depending on the seriousness of the charge.[3]

[9] The College's position is that the Supreme Court of Canada in *F.H. McDougall* [4] rejected those earlier authorities and conclusively established that there is a single civil standard of proof in civil proceedings.

[12] The Committee accepts that, while at one point there was some divergence in judicial opinion, the judicial pronouncement in *McDougall* is authoritative on the matter of the standard of proof applicable to disciplinary charges pertaining to physicians in Saskatchewan.

F. EVIDENCE

[13] The parties submitted an Agreed Statement of Facts and Documents. In addition, the College called six witnesses:

- Dr. Meredith McKague, an expert witness;
- Patient #1;
- Ms. P, a friend of Patient #1 who was contacted by Patient #1 directly after her final attendance on Dr. Mohammed;
- Patient #2;
- D.M., Patient #2's boss, to whom the patient reported inappropriate conduct by Dr. Mohammed directly after her final attendance on him; and

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[3] *Huerto, supra*, note 2; *Continental Insurance Co. v. Dalton Cartage Co*, 1982 CanLII 13 (SCC), [1982] 1 S.C.R.; 164; *Re: Camgoz and CPSS*,(1989), 74 Sask. R 73 (SKCA)

[4] *F.H. v. McDougall*, 2008 SCC 53; Further, the College cites *Dr. Ali v. College of Physicians and Surgeons*, 2013 SKQB 38 (Zarzeczny J), leave to appeal to Saskatchewan Court of Appeal denied: 2013 SKCA 23. In that case the College discipline hearing committee specifically applied the *McDougall* standard. The Saskatchewan Court of Queen's Bench did not disturb the committee's findings regarding standard of proof, which did not appear to have been challenged on appeal. To the same effect, see Discipline Hearing Committee of the College of Physicians and Surgeons of Saskatchewan re *Dr. Pillay* (August 12, 2016), which was not disturbed on appeal by Dr. Pillay to the Saskatchewan Court of Queen's Bench.

- N.R., a third female patient who, while not a complainant in these proceedings, testified to inappropriate conduct by Dr. Mohammed.

Dr. Mohammed testified in his own defence and called two witnesses:

- Ms. Craig, his office assistant;
- Dr. Margaret England, an expert witness who testified to standards of care of an endocrinologist.

Evidence of Dr. Meredith McKague re Qualifications

[14] The College asked that Dr. McKague be qualified to give opinion evidence regarding the standards of the medical profession when performing a physical examination, including a stethoscope examination, and maintaining appropriate professional boundaries. Dr. Mohammed objected on the basis that she is a Family Medicine clinician and instructor, not a specialist in endocrinology The Committee received evidence of Dr. McKague's qualifications before ruling on this issue.

Direct Examination re Qualifications

[15] Dr. McKague obtained her MD at the University of Saskatchewan in 1994 and undertook her Family Medicine Residency at Queen's University in 1996 before obtaining her MSc at the University of Calgary in 2000, in Community Health Sciences. She obtained her certification in Family Medicine in 1996 and since 2009 has been a fellow of the College of Family Physicians of Canada. She has at various times been licensed to practice in Ontario and Alberta and since 2002 in Saskatchewan. She has taught in various capacities from 2002 to 2010. From 2010 to date she has served as Associate Professor, Department of Academic Family Medicine, University of Saskatchewan. From 2014 to date she has served as Assistant Dean Academic, UGME, College of Medicine. She has received numerous honours and awards, primarily in recognition of her teaching skills.

[16] Prior to a new curriculum in 2014, Dr. McKague was in charge of clinical skills courses including medical examinations, ethics, and professional boundaries. From 2008-2009, in her capacity as Chair, National Clinical Skills Review Working Group, College of Medicine, she compared clinical skills at the University of Saskatchewan to national standards and worked on those national standards, including those taught to all medical students across the country in areas including physical examinations, interviewing patients, and communication skills. She also teaches communication skills, professionalism, and physical examination skills to residents and at CME courses. Since 2014, her time is spent approximately 70% on academic and administrative duties and 30% on clinical duties. Although she primarily teaches Family Medicine Residents, she also teaches communication skills within the specific context of physical examinations to Residents in a variety of other fields. All medical graduates, including those entering endocrinology, receive training in physical examinations, ethics, and boundaries: the underlying principles of conducting a physical examination, including appropriate communication, apply equally no matter what type of physician is performing it.

Cross-examination re qualifications

[17] In cross-examination on her qualifications, Dr. McKague testified as follows:

- She has 200-250 of her own patients and spends 2.5 days per week on her clinical practice.
- She has no special training in thyroidology or endocrinology, although all medical students and residents have some training in thyroid assessment. She takes regular CME, which includes components on thyroid disease, and follows literature on common thyroid disease.
- She was not aware of different standards of practice for endocrinologists regarding physical examinations, including stethoscope examinations. Although treatment and diagnostics may differ, basic care is the same.
- There is more than one way to conduct a physical examination and physicians can exercise their judgment as to how to examine a patient. Specialty knowledge applies to the interpretation of tests.
- Having reviewed the patient charts, she agreed that the referrals of Patient #1 and Patient #2 to an endocrinologist were appropriate and that these patients needed the special assessment, examination and treatment an endocrinologist can provide.
- She was qualified as an expert witness once in court in 1998 (regarding patient competency) and was engaged once by the College regarding standards of care of family medicine specialists.

Submissions and Ruling re Qualifications

[18] The College argued that Dr. McKague was clearly qualified in the area of communications and the proper conduct of patient examinations, and that issues related to professional boundaries pervade all of medicine. Endocrinologists are physicians first, specialists second.

[19] Dr. Mohammed submitted that Dr. McKague's testimony is not relevant or necessary and in any case she is not qualified to give opinion evidence as to the standards of care of an endocrinologist. Dr. Mohammed notes that he is charged under Bylaw 8.1(b) (ix) for failing to maintain the standards of the profession. Bylaw 8.1(a)(i) defines "standard of practice of the profession" to mean "the usually and generally accepted standards of practice expected **in the branches of medicine in which the physician is practicing.**" [emphasis added]

[20] Both parties provided briefs in support of their respective positions. We ruled on the matter orally at the hearing, and now provide our written reasons.

[21] The criteria for admissibility were stablished by the Supreme Court of Canada in *R. v Mohan*[5]and affirmed in *R. v. J. (J.L.)*[6]

(a) The evidence must be relevant to some issue in the case;

(b) The evidence must be necessary to assist the trier of fact;

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[5] (1994), 89 CCC (3d) 402

[6] 2000 SCC 51

(c) The evidence must not contravene an exclusionary rule; and

(d) The witness must be a properly qualified expert.

[22] The test for admissibility was further refined in *White Burgess Langille Inman v. Abbott and Haliburton Co.*,[7] where the Supreme Court of Canada held that the 4 *Mohan* criteria constitute the first step in the determination of admissibility.[8] "At the second discretionary gatekeeping step, the judge considers whether the potential benefits of admitting the evidence in justify the risks."[9] These principles were more recently summarized in *R. v. Abbey.*[10]

[23] We agree with Dr. Mohammed that as the party tendering Dr. McKague's evidence, the College has the evidential and legal burden to satisfy the *Mohan/White Burgess* admissibility criteria on a balance of probabilities.

[24] Dealing first with the 4-part test, we conclude:

(a) **Relevance**: The issues before the committee include whether certain stethoscope and other examinations were medically appropriate; whether they were conducted in accordance with the standards of the profession; and whether certain other behaviours (touching and communication) violated the standards of the profession in relation to professional boundaries. As Dr. McKague was put forward to give opinion evidence as to the applicable standards of the profession, her anticipated evidence was clearly relevant to the issues.

(b) Necessity: In a disciplinary hearing, panel members are expected to apply their own medical knowledge and experience to assess the evidence, but are not to use their own knowledge to establish the standards of the profession.11 The specialized knowledge of the two physician Committee members will assist them in assessing the medical evidence, but this does not render Dr. McKague's evidence unnecessary. Indeed, Dr. McKague is the only expert proposed to provide opinion evidence on the standards of the profession regarding conducting physical examinations and maintaining professional boundaries. While Dr. Mohammed intends to call an expert witness to provide opinion evidence as to the professional standards of an endocrinologist, this does not obviate the necessity of Dr. McKague's testimony.

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[7] 2015 SCC 23

[8] Ibid, para 23.

[9] Ibid, para 24, which goes on to state: "The required balancing exercise has been described in various ways. In *Mohan*, Sopinka J. spoke of the "reliability versus effect factor" (p. 21), while in *J.-L.J.*, Binnie J. spoke about "relevance, reliability and necessity" being "measured against the counterweights of consumption of time, prejudice and confusion": para. 47. Doherty J.A. summed it up well in *Abbey*, stating that the "trial judge must decide whether expert evidence that meets the preconditions to admissibility is sufficiently beneficial to the trial process to warrant its admission despite the potential harm to the trial process that may flow from the admission of the expert evidence": para. 76."

[10] 2017 ONCA 640, paras 47-48.

[11] *Ali v. The College of Physicians and Surgeons of Saskatchewan*, 2016 SKQB 42, paras 31-34.

(c) **Exclusionary rules**: No exclusionary rule applies in this case.

(d) **Properly qualified expert**: Dr. McKague is well qualified to give evidence as to what medical learners are taught and what is expected of all members of the medical profession with respect to the general principles of physical examinations, including stethoscope examinations, and professional boundaries. The proper question is not whether this is the *best* qualified expert available but whether she is *properly* qualified. Dr. McKague clearly has specialized knowledge that is outside the knowledge or experience permitted to be used by the Committee in the areas in which the qualification is sought and her opinion will assist the Committee in assessing the evidence in this matter.

[25] Even if the four requirements are met, the courts caution against easy admission of such evidence. We are of the view that the proposed expert evidence not only meets the preconditions to admissibility, but its "relevance, reliability and necessity" offer sufficient benefits to the hearing process to warrant its admission despite the potential "consumption of time, prejudice and confusion" that may flow. Without it, the College risks being unable to put forward the theory of its case without asking committee members to decide the case based on their own knowledge and experience rather than on evidence properly brought before them. Against this, Dr. Mohammed had confirmed his intention to put forward an endocrinologist as an expert witness: his witness could provide clarification in the event that she can establish practices within the field of endrocrinology that differ from those of the medical profession at large. In the end, the benefits of the proposed testimony to the hearing process outweigh any potential prejudice to Dr. Mohammed.

[26] The Committee also was mindful that the College need not prove every element of the charge. The Committee may accept some but not others: the Bylaw charge relates to standards of the particular branch of medicine, but the general charging provision of the Act, section 46 (o) relates to the standards of the profession overall.

[27] Having adjourned to consider oral and written submissions from both counsel, the Committee ruled that Dr. McKague was qualified to give opinion evidence on the terms proposed, for these reasons:

(a) The charges against Dr. Mohammed (to be read disjunctively) fall under both the general charging section of the Act[12] and the bylaw provisions. A finding under the general provision may be made independently of any finding under the bylaw.

(b) The College was not proposing that the witness offer opinion evidence as to whether a physical examination (including a stethoscope examination) was clinically indicated.

(c) Rather, the College was careful to limit the proposed parameters for the opinion evidence to "the standards of the profession when performing a stethoscope examination."

[12] Section 46 (o)

(d) Dr. McKague testified that the standards for performing a physical examination, including a stethoscope examination, apply to all physicians.

(e) Dr. McKague's combination of clinical and teaching experience regarding ethics and boundaries qualify her to give opinion evidence.

Dr. McKague – Substantive testimony

Direct Examination

[28] In preparing for her testimony, in response to questions from the College, Dr. McKague reviewed a number of professional guidelines and standards from registries; the Colleges of Physicians and Surgeons of British Columbia, Alberta, Saskatchewan and Ontario; basic standard physical examination textbooks; literature related to professional boundaries; and patient records provided by the College regarding two patients.

[29] At the College of Medicine she is Course Director for several undergraduate medical clinical skills courses. She teaches physical examination skills, communication skills, and ethics to medical students and residents.

[30] The following general principles apply to any type of physical examination:

- A physician should ask a patient's permission before doing the physical examination; describes what is being examined and generally the reason why; give instructions during the examination; and briefly describe findings to the patient. These steps minimize the chance of a patient misinterpreting an examination.
- A physician should pay attention to draping during an examination so that the part of the body that is required to be exposed is draped and the patient is re-draped as soon as possible after the examination.

[31] The standards of the medical profession require that a physician performing a physical examination:

- ask permission to examine;
- treat patients with respect during the examination, being sensitive to their modesty;
- take steps to ensure the patient understands the intention behind the physical examination and the findings; and
- communicate with the patient during the physical examination to ensure their comfort.

[32] Medical students are taught, and it is a standard of the profession regardless of specialty, to document pertinent positive and negative findings of the physical examination in the medical record. College bylaws include a statement that physical examination findings are recorded in the medical record.

[33] In general, if a chest auscultation of the heart area is indicated, a physician is also expected to obtain and record vital signs such as pulse and blood pressure. Vital signs are a standard part of many examinations in many clinical contexts, If one is suspicious of cardiac function abnormalities, vital signs assist with assessing.

[34] The purpose of a stethoscope examination generally is to allow the physician to hear amplified sounds, typically from organs, underneath the skin. Physicians may auscultate the

heart or other structures in the chest: for example, in a respiratory examination, the lungs. The purpose of a cardiac examination would depend on the clinical context. For example, as part of a screening examination a physician might check for valvular heart disease or other conditions that may not yet have presented with symptoms. In a patient with known cardiac disease, it would be to monitor for stability of symptoms, or to try to identify changes.

[35] In an auscultation of the heart, physicians listen for the normal heart sounds, called S1 and S2. They also listen for any extra, abnormal heart sounds, called S3 or S4. They listen for murmurs and check the rate, the amplitude of the heartbeat. In conducting a stethoscope examination of the chest, medical students and residents are taught to examine four cardiac listening posts: 1. The second intercostal space just to the right of the sternum; then 2. The same position just to the left of the sternum, then; 3. The left lower sternal border, and then; 4. The fifth intercostal space in the midclavicular line (the mitral post). These listening posts are the areas where one is most likely to hear particularly murmurs associated with certain valves the loudest.

[36] While it is not uncommon that respiratory sounds might be listened to through thin clothing, students and residents are taught to try to listen with a stethoscope against the skin to hear cardiac sounds because murmurs can be subtle and hard to hear.

[37] Learners are taught to be particularly sensitive when conducting chest auscultation in an adult female, because the breasts can be sexualized parts of the body. The standards of the medical profession require asking permission before performing a stethoscope examination, paying attention to patient comfort and modesty, and explaining the findings briefly.

[38] Professional boundaries help a patient and physician to maintain a professional, as opposed to personal, relationship. A “boundary crossing” refers to a variation from typical practice in interacting with a patient, that may cause the patient to feel uncomfortable, but is not intended to be exploitative and does not harm the patient. A “boundary violation” is exploitative and causes or has potential to cause harm to the patient.

[39] Physicians have knowledge that the patient may not and societal expectations around physicians may cause patients to feel vulnerable. Medical students and residents are taught that due to a power differential, real or perceived, they should take care never to interact in a way with a patient that is exploitative. They are generally taught that they should limit physical touch to the clinical examination: non-clinical physical touch may sometimes be appropriate, but only with the patient's permission. For example, if a patient is grieving and weeping, it may be appropriate to ask if they would like the physician to hold their hand. But generally, medical students and residents are taught to be cautious of this type of touch as it may not be welcomed. These principles apply to all physicians, regardless of area of practice.

[40] Medical students and residents are taught that questions about a patient's personal life—hobbies, relationships, or work, for example—can be appropriate, depending on the context. Many illnesses affect a patient's function in different spheres of life and this information can help the physician to understanding the impact of illness on the patient. Also, casual small talk, can help a nervous patient feel more comfortable and establish rapport. Learners are taught not to ask personal questions of a sensitive nature unless in the context of the patient's presenting concern. All practicing physicians are expected to act in accordance with those principles regardless of speciality. The standards of the profession require that the physician keep in mind

always that the intention of the visit is to benefit the patient; to be aware of professional boundaries during all patient interactions; and to try to minimize patient discomfort.

[41] Dr. McKague was asked to respond to a number of assumptions:[13]

Assumptions re Patient #1

1. Assume that when conducting a stethoscope examination of Patient #1, she was sitting on a chair, and Dr. Mohammed was standing in front of her. Assume that Dr. Mohammed placed his hand with a stethoscope down the front of her shirt and placed the stethoscope on her "cleavage" (near the sternum between her breasts), asking her to lean forward towards him.

[42] It is generally taught that the ideal situation is to have the patient seated on the examination table so that the physician, when standing, is at approximately the same height. If the physician stands over a patient seated in a chair, the patient is in a more vulnerable position; it is preferable for the physician also to be seated. Most offices have a chair or a stool with wheels, allowing the physician to wheel around and change position in doing an examination.

[43] Regarding technique, it would be appropriate to place the stethoscope near the sternum between the breasts on the left side to auscultate the left lower sternal border or the third cardiac listening post. Typically, physicians would listen at four cardiac listening posts, though there may be contexts where that is not done. The forward-leaning position is a little unusual. Patients will be asked to lean forward as part of a complete cardiac examination if one is particularly listening for a murmur of aortic regurgitation. In such cases, the patient is asked to exhale in a forward-leaning position, and the physician would listen typically in the aortic area in the left lower sternal border. More context would be required to know whether that was the reason the examination was done with the patient leaning forward.

[44] Regarding the physician putting his hand down a patient's shirt with a stethoscope, normally, because of the proximity of the breast to the area that one is examining, one would ask a female patient to bring the shirt down herself if possible, to listen to the two upper cardiac listening posts, and if the shirt was able to come down enough to lap to the left lower sternal border to do so. If the shirt could not come down that far, the physician may need to slide the stethoscope down the front of the shirt to listen to the left lower sternal border. It would be important to ask permission to do so. If a patient had a button shirt, one would ask the patient to undo the top couple of buttons to expose the left lower sternal border. Another option is to have the patient draped in a gown, which is easily adjusted to allow for the examination.

Assumption 2: Assume that when Patient #1 returned to see Dr. Mohammed one month later to follow up blood work results, he brushed the hair from her neck, rested his hand on her shoulder and palpated her neck. Assume he then performed a stethoscope examination in the same manner as described above.

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[13] Exhibit C3

[45] Learners are taught that if one needs to expose an area of the patient's body, it is better to ask the patient to expose that area as opposed to the physician doing it, and to explain the reason. This includes moving hair from the neck, or bringing up a shirt for an abdominal examination.

[46] It is difficult to say whether Dr. Mohammed resting his hand on a patient's shoulder was related to the clinical examination, without understanding the context of the examination. Normally, if examining skin tone, turgor or elasticity, a physician would ask permission to and explain what they are doing that examination. Resting a hand on the shoulder would not be part of the examination of the neck or the thyroid.

Assumption 3: Did Dr. Mohammed record the results of a stethoscope examination in the records of either appointment and are you able to identify any indication for a stethoscope examination on the August 18, 2016 visit?[14]

[47] Dr. Mohammed's records for the July 19, 2016[15] and August 18, 2016[16] attendances do not contain any reporting of a stethoscope examination. If an examination is medically indicated, it should be recorded, even in the context of a consultation report.

Assumption 4: Assume that when patient #1 got up to leave the examination room, Dr. Mohammed stood in front of the door with his foot against the door and put his arm firmly around her lower back and hip. Assume he allowed his hand to trail across her buttocks and also looked at her buttocks.

[48] In the context of appropriate professional boundaries, Dr. McKague opined that these behaviours would certainly lead a patient to feel vulnerable and she did not see how they would be a part of a clinical examination. This would be a boundaries violation.

Assumptions re Patient #2

Assumption 5: Assume that when Patient #2 attended on Dr. Mohammed on August 4th, 2016, he repeatedly touched her forearm and shoulder and placed his hand on her right shin.

[49] Placing the hand on the right shin could be part of a clinical examination, checking for peripheral edema, which can happen in the setting of hypothyroidism or low thyroid, or in the setting of heart failure, which rarely could result from hyper or hypothyroidism. Repeated touching of the shoulder and forearm to examine the skin texture and turgor could be part of a clinical examination. It would require the physician to explain and ask permission. Asked if touching the skin to examine texture involves resting a hand, or other types of touching, she opined that typically, one would take the skin between thumb and index finger, palpating with

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[14] Tab 2, page 4 and Tab 4, page 9

[15] Tab 2, page 4

[16] Tab 4, page 9

the tips of the fingers and then lifting or lightly pinching the skin. The patient would need to be told this was part of the examination.

[50] Typically, checking for edema in the course of a physical examination involves asking the patient to pull up their pants, then, over the front of the shin, usually, with the tips of the fingers, often the index finger, pressing over the front of the shin to see if there is indentation and how quickly that indentation resolves after the pressure is lifted. It involves poking the shin with the fingertip, not resting the hand on it. If the physician is touching a patient for the purposes of clinical assessment, one would expect the physician to be looking at the area being examined. The consultation report regarding Patient #2's August 4, 2016 attendance[17] makes no reference to an examination of the skin or examination for edema.

Assumption 6: Assume that Dr. Mohammed placed his hand and the stethoscope under patient #2's dress and bra from the top of that dress and placed the stethoscope on her left breast in the areolar region and then moved it to a spot about an inch higher.

[51] This would not constitute an appropriate stethoscope examination, where, for cardiac auscultation purposes, one would listen in the cardiac listening posts. Listening over breast tissue is likely to reduce the effectiveness of the examination because heart sounds would not be heard as clearly, and there is no cardiac listening post in the areola region.

Assumption 7: Did Dr. Mohammed record the results of the stethoscope examination on the August 4, 2016 attendance, and are you able to identify any indication for a stethoscope examination on the August 4, 2016 visit?

[52] The report on this attendance[18] does not record either a stethoscope examination or vital signs.

Assumption 8: Assume that Dr. Mohammed asked Patient #2 about her vacations and her work and asked her if he could visit her at her work.

[53] It is possible that briefly asking about vacations and work that might relate to function would be done with the intention of understanding a bit about the patient's life context to determine if illness was having any impact on function, or to help the patient feel more at ease. In the context of a patient with an illness where function is a large component of the assessment, e.g. certain psychiatric illnesses, it might be more appropriate to have a longer conversation about those aspects. However, asking to visit a patient at work would not be respectful of professional boundaries.

Cross-examination

[54] Dr. McKague acknowledged that:

- A physician's failure to explain the purpose of a physical exam before performing it, does not on its own mean that the exam was not performed properly; and

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[17] Tab 13, p. 27

[18] Tab 13, p. 27

- "Standard practices" and "best practices" are not the same. There is a spectrum of practice. Not following the best practice does not on its own mean failure to meet the standard of practice expected.

[55] In a stethoscope examination on a female patient, the stethoscope may very well be on or near the breast – on medial breast tissue when listening at the left lower sternal border. accidental or incidental contact between the stethoscope and other portions of the breast would be highly unlikely: a physician knows from training where to place the stethoscope and is very aware of the anatomical landmarks.

[56] On the issue of patient perceptions, Dr. McKague acknowledged:

- Different patients may perceive the same action in different ways. Something a physician does could greatly upset one patient and not affect the other in the slightest. A physician could do something perfectly innocent and non-exploitative, but a patient could perceive it as inappropriate or exploitative.
- A patient's reaction or non-reaction to something a physician does not determine the appropriateness of the physician's action. One needs to consider whether the act was medically indicated and done in accordance with the applicable standard of practice.

[57] Medications a patient is taking are relevant to examination and assessment.

[58] Turning to the assumptions regarding the stethoscope examination during Patient #1's July 19, 2016 attendance on Dr. Mohammed, it is standard for the patient to be seated: whether in a chair or on an examining table would not affect the efficacy of the examination.

[59] Only during a complete cardiac chest exam, if there was a concern about aortic regurgitation, would a physician ask a patient to lean forward, in which case one would ask the patient to exhale and hold their breath.

[60] Dr. McKague did not accept that a stethoscope exam of the heart can be performed without auscultating all four listening posts: listening in only one or two areas of the four would be an incomplete examination. Listening to all four areas is not a best practice—it is a standard practice.

[61] As to Assumption 2, regarding Patient #1's August 18, 2016 attendance, brushing a patient's hair aside on its own, while not inappropriate, is not a best practice. A physician's hand could reasonably come into contact with a patient's shoulder while, for example, taking blood pressure or pulse, or steadying the patient while examining the neck, if the patient appeared to have difficulty steadying themselves.

[62] There can be a significant variance in what different physicians record in a chart. For example, the letter of November 13, 2014 from Dr. Mohammed to the referring physician,[19] written by a Jursi, [20]is a really good note, an example of best practices.

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[19] Tab 19, page 38

[20] Junior Undergraduate Rotating Student Intern

[63] Regarding assumption 4, if a physician placed a hand on the upper or midback of a patient as they were leaving the examination room, it would certainly be a boundary crossing. She could not say if it would be a boundary violation without knowing the intention.

[64] Regarding assumption 8, it would not be inappropriate for a physician to be at a patient's workplace if that is a place that the physician happens to frequent, for example to be at a grocery store if the patient happened to work at that store.

Evidence of Patient #1

Direct examination

[65] Patient #1 lives in Regina and is 43 years of age. She has worked in administrative positions for the past 16.5 years, in recent years with a federal government agency. When she first saw Dr. Mohammed, she had been on thyroid medication for a condition diagnosed 10 years previously. Her doctor referred her to a specialist as she was starting to experience some of the same symptoms that resulted in her starting medication in the first place.

Appointment of July 19, 2016

[66] In Patient #1's first appointment, after she had completed a questionnaire, Dr. Mohammed came into the examining room and sat in his computer chair, to her right as she was seated. He asked questions about her thyroid problem and medication. He then stood in front of her and felt around her throat. She did not know how a thyroid exam was supposed to go. He listened to her chest. Without warning or discussion, he pulled her shirt out, "stuck his hand down the front of my shirt and had me lean forward." She thought it odd that he did this as no doctor had done that to her before. He placed the stethoscope on top of her breasts, leaving it on one spot. He arranged for blood tests and advised her to stay off the thyroid medication and to follow up with him when the blood work results came.

Appointment of August 18, 2016

[67] Patient #1 thought she was just to receive the lab results. She sat in the chair while Dr. Mohammed stood at his computer, looking at the lab report. He told her she should discontinue thyroid medication, because low vitamin D was the cause of her problems. She should take Vitamin D pills and return in 6 months for repeat blood work. He started smiling at her and asking her questions, such as what she did for work and whether she had children. He asked three different times if she lived in the city, then put his hand on her shoulder and with the other hand brushed her hair away from her shoulder and started feeling her throat again, which lasted 5 or 10 seconds. He said he wanted to listen to her chest again, and again stuck his hand down the front of her shirt[21] and asked her to lean forward, placing the stethoscope on the same spot, between her breasts on her cleavage, again without moving it. She was wearing a thin tunic. He said he would see her at the next appointment and as she was leaving, asked whether she had a

[21] The tunic was marked as an exhibit. Patient #1 had not worn it since this attendance and did not want it back.

husband or boyfriend.[22] She replied that she did not and joked that maybe that was why she was so tired all the time.

[68] She went to open the door, got it open about 2 or 3 inches, and he was right there, standing in front of the door, with his foot blocking the bottom of the door from opening, and his whole body against the door. He put his left arm around her lower waist and hip and pulled her right into him so that the whole right side of her body was pressed up against the middle of the front of his body. She leaned away from him, trying to take a step away. He just stared into her face smiling and firmed up his grip. She does not remember exactly what she said as she was in shock, thinking he was going to kiss her. He said, "I could see you in three months instead, would you like that?" She thought he was asking her on a date. She said she could return within 3 months. He then smiled and let her go. As she was walking outside the door, she felt something she thought was his hand "go across my butt." She saw him staring down where her butt would have been, then said "let's go to the front and book your appointment." She said "Okay, I'll follow you", and he replied "No, no, I'll follow you." She felt like he was staring at her butt again and when they got to the reception desk, she came to the front and he stood to the side of it. He gave her a Vitamin D prescription and she left with an appointment card to return in three months. She tried phoning her mother, but as she was busy, she called P, her friend of 22-23 years. She told P that she thought she had just been violated by her doctor. She cried in her car while they were talking. P told her to be careful while driving to pick up her Vitamin D. Patient #1 then phoned another friend and told her.

[69] Patient #1 left the appointment confused and upset. She had never felt like that leaving a medical appointment before. She had never had a stethoscope examination performed in the way she described. She had previously seen another endocrinologist, who did the examination, with many medical students in the room, on top of her shirt, moving the stethoscope around in different spots, without having her lean forward.

[70] Patient #1did not return to see Dr. Mohammed. She reported him to the police. She has been very nervous about seeing new male doctors since, to the point of wearing a fake engagement ring to deter inappropriate behavior. She was later refused medical treatment in front of her daughter by a doctor who was aware that she had filed a complaint against a doctor. She has suffered from anxiety, mood swings and sleep problems. She had to drive to Saskatoon to see another endocrinologist. She does not know the other complainant in this matter and has not spoken to her.

Cross-examination

[71] Patient #1's GP referral note of May 31, 2016 stated, "She is complaining of severe tiredness and change in voice recently." The change in voice had been going on for about six months. She was on Tapazole for hyperthyroidism, starting about 10 years ago, but stopped after a few years when the condition went into remission, and resumed it a few years later. She was also on medication for colitis.

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[22] Patient #1's Personal History Form showed that she was "single" with two children and set out her occupation. While not specifically indicating where she lived, the form listed her pharmacy as being one in Regina. Ex. C-3, Tab 2, p. 3

[72] On Patient #1's July 2016 attendance, the receptionist asked her to sit in the examination room chair. Patient #1 did not request a chaperone nor have a friend or family member with her. Dr. Mohammed told her he needed to listen to her chest. Only the stethoscope touched her skin—Dr. Mohammed's hand did not.

[73] On the August 18, 2016 attendance, she was again alone and did not request a chaperone. Asked whether she felt comfortable enough to be in the examining room with Dr. Mohammed on this second appointment, she replied that she thought she was just getting test results. Again, the receptionist asked her to sit in the same chair. When he first came in, Dr. Mohammed did not appear to even notice her. He went straight to his computer, then kind of did a double take, smiled at her and started asking her questions. He touched her neck before the stethoscope examination. He brushed her hair, at that point almost down to her waist, away from her neck and shoulders. He already had his hand on her shoulder before he did the stethoscope examination. When he said he needed to listen to her chest, she did not argue, but was not sure why he needed to check her again when he had just told her the problem was related to Vitamin D. Again, only the stethoscope, and not his hand, touched her skin. When she got up to leave and he blocked the door, his front was facing her right side. He "scooped her," grabbing her and pulling her in to him. Her right arm was between the two of them the entire time while at the door. Ultimately, he stepped back and she was allowed to open the door. She felt something "trail" or "brush" against her buttocks. She did not dispute that this was a light contact and she did not see it as she was facing the other way, towards the exit. When she turned around he was smiling, staring down. Dr. Mohammed never asked her out, but he would not let her go until she agreed to return in 3 months. He did not ask her any sexually-oriented questions.

Evidence of Ms. P

[74] Ms. P of Regina, a good friend of Patient #1 for over 20 years, recalled receiving a phone call from Patient #1 in August 2016 at around 4 p.m., just before leaving work. As Patient #1 sounded upset, P went into a private boardroom to take the call. Patient #1 told P that she had just come from a medical appointment and thought she had been assaulted. She told of a thyroid exam that made her feel uncomfortable, that the doctor was touching her neck, brushing away her hair. He put his hand down her shirt with a stethoscope and made her lean over. He put his hand around her waist. As the appointment was ending he blocked the door, asked personal questions, such as where she lived, and when she was about to leave he kind of brushed up against her buttocks. Patient #1 was very emotional. It was unusual to get this type of call from her. Patient #1's son is P's nephew.

Evidence of Patient #2

Direct Examination

[75] Patient #2, of Regina, is 40 years of age. She is the full-time director [redacted] (since 2010) and also works on a casual basis as a [redacted] (3-4 years in her current position). In 2016, her G.P. referred her to Dr. Mohammed for advice on which hypothyroidism medication had the least serious side effects, given her wish to conceive a child. She completed a patient intake form that confirmed her occupation as a [redacted], her marital status as single, and that she had no children. Nothing stands out from

her first attendance on Dr. Mohammed on April 6, 2016 as inappropriate. They talked about her [redacted] work, noting that her office was not far from Dr. Mohammed's.

[76] By the time of her second appointment, on May 3, 2016, there was more touching than at the previous attendance and it felt inappropriate. There was a slightly-longer-than-usual handshake and touching on her arm that was different than the first time. She was wearing a long-sleeved shirt and there was eye-to-eye contact, which did not appear to her to be part of a physical examination. And, she did not see him looking down at her skin as he was touching her arm. There was no poking or pinching of the arm, as might be part of an examination. What mainly stands out is that the stethoscope was put up her shirt rather than down the top, even though it was a button-up shirt. This had never been done to her before by doctors listening to her heart. The stethoscope did not go on her breast. She does not recall any discussion about the stethoscope examination before it occurred. There was some discussion about her summer plans, which included going on holidays to B.C. with her boyfriend.

[77] At her third appointment on June 14, 2016, a female JURSI attended with Dr. Mohammed and conducted the physical examination, which Patient #2 was happy with. The examination seemed appropriate. As to treatment plan, she was to discontinue Tapazole.

[78] Patient #2 understood that the purpose of her fourth appointment with Dr. Mohammed on August 4, 2016 was to follow up on her blood work and see if medication adjustments were needed. When Dr. Mohammed entered the examining room there was a handshake, right hand to right hand, with his left hand on her exposed right shoulder, as she was wearing a dress with straps. The length of the interaction made her feel uncomfortable. She was directed to a chair where she sat between an examination table and a desk, with her back to the wall. She crossed her legs, at which time she was subjected to what she thought was inappropriate conversation and inappropriate touching. Dr. Mohammed moved the chair from his computer desk towards her so that she was, in essence, cornered. With his left hand on her right shoulder, he put his right hand on her shin, close to her knee. He was not poking her shin - it was just his full hand on her shin. She had not noted any edema in her shins leading up to that attendance and it was not something she recalls discussing with respect to her thyroid function. While he had his full hand on her shoulder, she did not see him looking at the parts he was touching: he was looking at her face. Both touches were on exposed skin, for a period of 3 - 5 seconds. He was looking at her face, not her leg or arm and there was nothing to indicate it was part of a physical examination. She did not consent to him touching her in those two spots. He told her he had been thinking of her, which she though was an odd statement to make. She asked, 'Why, did you know I had an appointment coming up?' He said, 'No, I was just thinking about seeing you.' There was a lot of personal conversation and small talk. He asked about her holidays and touched her as maybe a friend would, but not appropriately as a physician, without consent to touching parts of her body that were exposed skin. Then he asked if she was happy to see him. That made her very uncomfortable. She replied, 'No, because the more I'm here, it means that maybe something is wrong.' She could not wrap her mind around what the point of that statement was. To her mind, at this point there was no formal examination. It was all chitchat, inappropriate touching and inappropriate questions. He asked where her office (not the [redacted] where she worked) was, then asked, 'Can I come see you?" She immediately said "No." He said, "Oh, I just thought I could some see you." She again declined. In her mind, there was no context as to why he would want to see her and it was not an appropriate place for the

discussion to go. If he was asking something medical in nature, he did not indicate that. After she said “no”, finally it appeared that a true medical examination was starting.

[79] Dr. Mohammed sat in a chair, went over her lab results and asked about her symptoms. He touched her thyroid, appropriately, and said it was not enlarged. Then, without asking, he put the stethoscope on her chest, but not in a place where she had usually had a stethoscope put, to listen to her heart. He put it on her left breast, right on the skin, slightly underneath her brassiere, slightly touching her areola from above, for a couple of seconds, then to a place that she thought was more appropriate that was not on breast tissue. He wrote a prescription and talked about booking another appointment to review her lab tests, but by that point she was not focused on his conversation—she was upset and wanted to get out as soon as possible. She had never felt like that after a medical appointment before. She left the office and returned to work where she walked straight into her CEO’s office. There was discussion about making a complaint to the SMA about what she had just experienced. Patient #2 told her CEO about inappropriate touching, an inappropriate stethoscope examination, and personal questions.

[80] Patient #2 never returned to see Dr. Mohammed. She carried subconscious anxiety afterwards. She worried about all the time and effort she would have to put in telling her story over and over again following a complaint in which she had nothing to gain, and wondered if she would be believed.

Cross-examination

[81] Patient #2 acknowledged that she had never been examined by an endocrinologist before she saw Dr. Mohammed.

[81] At the time of referral, she had been taking propylthiouracil for hyperthyroidism for 3-5 years and Celebrex for several years for aches and pains in her joints, which, before her thyroid diagnosis was thought to be related to fibromyalgia. She had taken Citalopram daily for depression and anxiety for a couple of years intermittently but did not recall if she was taking it at the time of the referral. Since around 2010 she was on Ventolin for swimming while in triathlon training.

[82] Patient #2 agreed that at the April 4, 2016 attendance, Dr. Mohammed noted that her Vitamin D was low and recommended she switch her thyroid medication. She understood there was a need for follow-up due to the change in medication and a need to monitor her thyroid function.

[83] She did not request a chaperone, nor have a friend or family member with her, even though she knew she would be in an examination room with Dr. Mohammed. She was comfortable being alone with him at the time of the April 3, 2016 attendance, but cautious by the time of the May 3, 2016 appointment. With a man touching her a little bit longer and looking at her in a certain way, her “spidey senses were tingling” and she felt uncomfortable, but as there was nothing she could prove, she went to the next appointment. She was comfortable at the June 14, 2016 appointment with the Jursi.

[84] At the August 4, 2016 attendance, in the absence of a chaperone, friend, or family member, she understood that she was seeing Dr. Mohammed in part due to the medication change. Dr. Mohammed walked with her to the examination room and guided her to the middle chair. He touched her right shin but she did not recall him squeezing it. She disagreed with the suggestion that the touching of the shin was only lingering. And, he was not looking at her leg.

She understood his questions about her work as getting at what she actually did in her role with the [redacted]. Dr. Mohammed never asked her out, but only if he could come to see her at her office.

Evidence of D.M.

[85] D.M. is 51 years of age and lives in Regina, where she is CEO of [redacted] where Patient #2 works. They had worked together for more than eight years. On August 4, 2016, Patient #2 came to see her on returning from a medical appointment. Patient #2 was deeply concerned and upset about an interaction with a physician. D.M. could tell this both by looking at Patient #2 and what she said. Patient #2 was upset both by how the doctor had interacted with her and touched her. The whole interaction was deeply concerning to her. D.M had never had a conversation with Patient #2 like that, either before or after.

Evidence of N.R.

Direct Examination

[86] N.R., a 34-year old Regina health professional, was referred to Dr. Mohammed in 2014 due to excessive sweating under her armpits, fatigue, and being shaky. She had not seen an endocrinologist before. She saw him 5 times between September 10, 2014 and June 15, 2015 and had no concerns about her initial appointments. Dr. Mohammed had a female student working with him.

[87] On April 15, 2015, Dr. Mohammed's receptionist called her name and took her to the examining room. Dr. Mohammed came in and stood by the computer. She told Dr. Mohammed she was not feeling well. He said he wanted to check her heart and while she was seated, stood in from of her, listening to her heart, down her v-neck shirt, with his stethoscope. He asked her to lean forward a bit while he listened to her left side somewhere around the breast. He did not move the stethoscope around but left it on one spot. She felt a little vulnerable and weak and wanted to know why she was feeling poorly. He pulled his stool from his computer desk towards her and sat down, putting his left hand on her left thigh, just above her knee. She was wearing jeans. He did not squeeze or move his hand, just rested it on her leg. Looking into her eyes and sitting close to her, he told her he would take care of her, that everything was going to be okay. Then the appointment was done. Walking down the hallway, he called out her name and asked her to follow him to a room behind the reception desk. The light in that room was off but he went in and she followed, although not fully entering the room. He pulled his cell phone out of his pocket and asked if he could call her sometime. She told him she didn't think that was a good idea at all and left the building. She sat in her car for a while, feeling confused. In the examining room, she had not been concerned as she thought Dr. Mohammed wanted to help and was concerned. Once he asked for her phone number, she felt otherwise about his intentions. She had never felt like that previously after leaving a medical appointment. She asked her GP to refer her to another endocrinologist, as she did not feel comfortable to see him again.

[88] Eventually, N.R. did see Dr. Mohammed once more, on June 15, 2015. She does not remember much about the appointment until the end of it. When she was about to leave the examining room, Dr. Mohammed looked at her and said, "There is something between us; isn't there?" She asked him what he meant. With his arms up he repeated this. She noticed he had a wedding ring and said, "Doctor, aren't you married?" He said, "I am, but us doctors, we don't

have time for that." She told him she had a boyfriend and he backed up and said "Whoa, whoa" with his hands up. She left the room and never went back. She felt vulnerable—she needed help and needed a professional to see what was going on with her. She lost a little hope. She does not know, nor has she ever spoken to, either complainant, but when she spoke to the College she was told that any complaints against a physician would be on their website and she did see their complaints there.

Cross-examination

[89] On cross-examination, N.R. acknowledged that in the spring, 2015, she was taking Ativan for anxiety (not for long and only as needed) and sertraline and venlafaxine, anti-depressants.

[90] She returned for the June 2015 appointment despite her discomfort, as there are not many endocrinologists in Regina, so she decided to "suck it up" and see Dr. Mohammed one more time, hoping he could help her.

[91] She repeated that she saw his wedding ring on his left hand, but could not remember anything about the ring. She had no way of knowing he was married apart from the ring. She was surprised to know that Dr. Mohammed does not wear, and has never worn, a wedding ring.

Evidence of Dr. Mohammed

Direct Examination-General Matters

[92] Dr. Mohammed, almost 60 years of age and a Regina resident, was married in 1983. He and his spouse have 5 children. He graduated from medical school in Libya in 1980, did rotating internships at teaching hospitals in 1981 and 1982 and was a house staff member at a Tripoli hospital in General Internal Medicine and Pediatrics from 1982 to1985. In 1985 he joined the teaching program for Internal Medicine at the University of Toronto where he applied for speciality competence in endocrinology, undergoing a two-year rotating residency, before being certified as an endocrinologist in 1991. He returned to Libya as part of teaching staff from 1991-1997. He learned of the need for an endocrinologist in Regina and since 1997 has worked with the other Regina endocrinologist and as a member of the teaching staff of the U of S medical school, in both medicine and endocrinology. Up to just before the hearing, there were three endocrinologists in Regina, but one just left.

[93] Endocrinologists deal with hormone disturbances. There are differences between what a GP might do with a patient and what an endocrinologist would do. The responsibility of a GP is to conduct a first-level screening and management, filtering cases that are more complicated, which may need more expertise.

[94] Dr. Mohammed practices in a building with 10 other physicians, sharing office space with an orthopaedic surgeon and a neurologist. The three doctors share a patient sitting area, but each has their own receptionist and computer system. The other doctors use the common hallway to access parking and the filing room behind the reception area for coffee and water. There is a drug store nearby that he visits once to four times per week. He has between 12,000 to 15,000 active patients but has between 3,000-4,000 patients not yet entered in their computer system. He sees between 15-20 patients on an average workday and works 4.5 days per week. His receptionist receives the referrals and arranges appointments. When patients come in, after taking health information and weighing the patient, the receptionist takes them to one of two identical examining rooms, asks them to sit down, opens the computer and enters data such as

weight and recent lab reports in the EMR. Then she informs Dr. Mohammed that the patient is in the examination room.

[95] Dr. Mohammed does stethoscope examinations to listen to the thyroid patient's heart, whether hyperthyroid (overactive thyroid) or hypoactive (underactive thyroid), or if they have a thyroid disease. Since he started practicing endocrinology, he conducts these examinations the same way, with the patient sitting on a chair. He holds the stethoscope usually at the diaphragm either in the centre or the upper half of the left side. He just needs to know if there are any abnormal heart sounds or there is any murmur and screening—not as a cardiologist. He would not normally listen to all four quadrants of the heart because that is not the purpose for which he is seeing the patient. Sometimes he sits in a chair and sometimes he stands, either way diagonally to the patient. Sometimes he asks the patient to lean forward, for two reasons: the heart sounds will be better because the heart will be a little closer to the chest wall; and certain cardiac abnormalities, such as pericarditis, are heard better with the patient leaning forward. Sometimes patients are asked to lean to the left to auscultate the mitral area, as the top of the heart comes close to the ribcage and the lung. Asked whether he would place the stethoscope under the patient's shirt or dress, he answered:

> Usually whenever it's accessible and there is no thicker clothing, I do it underneath the shirt. I slide the stethoscope to the upper part of the chest, or the central area. If the patient is wearing a very thin t-shirt, and I can hear it without interfering with the sounds, I may do it at the top, but ideally it (the stethoscope) should be on the skin directly.

[96] Asked as to his general practice of having physical contact with a patient leaving the examination room, he said that to give the patient priority and respect, he might have put his hand to lead the patient, "Please, go ahead. When I open the door, I lead him out of the examination room." He puts his hand at the upper shoulder between the blades, as part of his culture but he has stopped doing this since 2016, when he was informed that such a practice is not acceptable here.

Dr. Mohammed's Testimony re Patient #1

[97] As Patient #1 was suffering from hyperthyroidism, he wanted to know what medication she was on and the current status of thyroid function. Thyroid medication can take 4 to 6 weeks to assess. He knew Patient #1 had discontinued Tapazole two or three weeks before her first attendance. He probably conducted a stethoscope examination on July 19, 2016, due to complaints of extreme fatigue and recent change in medication. If she became hypo or hyper, the heart rate could be related to the recent medication change. His note to the GP of the July 19, 2016 attendance[23] also served as his office chart. It did not refer to a stethoscope examination because he usually refers to positive findings, or a negative important finding. He does not make any entry in the record if the examination is normal. He reports more widely if there is an internist. He wrote that he would reassess her within 4 weeks, as that would make 6

[23] Ex. C-3, tab 2, p. 4

weeks since she discontinued Tapazole, because if she was rebounding by then to hyper or hypo, this would start showing in the blood work and symptoms.

[98] Dr. Mohammed's next attendance on Patient #1 was on August 18, 2016. He had sent the patient for Vitamin D testing as there is a lot of overlap between thyroid dysfunction and symptoms (aching, tiredness, joint and muscle pain) and Vitamin D deficiency, the latter being common in Saskatchewan. He assumes he checked her thyroid again, because cysts can develop overnight in a thyroid gland. The thyroid exam consists of palpating the thyroid with his right hand, 99% of the time with the patient sitting in the chair, a practice he learned from eminent endocrinologists. To stabilize patients, he puts his left hand either at the shoulder or back of the neck and uses his right hand to examine both lobes of the thyroid and the isthmus, and to determine if there is a palpable lesion. When Patient #1 exited the examination room, he did not put his arm around her, pull her close to him or attempt to block her from leaving.

Dr. Mohammed's Testimony re Patient #2

[99] Patient #2 was referred to Dr. Mohammed by her GP. The referral letter indicates that she had thyroid disease and wanted to conceive. She was concerned about the safest way to manage her thyroid prior to getting pregnant and the potential risks of her medication, PTU, in that regard. In her first attendance, on April 6, 2016, Patient #2 introduced herself as a [redacted] Dr. Mohammed's letter to the GP of the same date noted vital signs, weight, and an assessment indicating "normal thyroid function, low Vit-D level" and a plan to switch to Tapazole and a Vit-D supplement and follow-up in four weeks. Dr. Mohammed testified that a number of her long-standing symptoms—muscle aches, joint pain, and fatigue—were typical for Vitamin D deficiency. He conducts a stethoscope examination for every patient with thyroid disease. He did not recall putting the stethoscope up her shirt from the bottom to listen to her heart but may have if the mitral area was more easily accessible. In 99% of cases he approaches from the top, as he did for Patient #1.

[100] On Patient #2's second attendance, on May 3, 2016, Dr. Mohammed wanted to see if she was having any symptoms from the different medication. He most likely would have conducted a stethoscope examination with the patient sitting in the chair, him standing and placing the stethoscope down the front of what she was wearing, listening to the upper half of the left side and the center of the chest. He might have asked her to lean forward. His report to the GP of that date[24] did not record that he conducted a stethoscope examination as he does not record normal cardiac findings. Likewise, while he conducted a thyroid exam, he did not record this because there was no change in her thyroid since the change of medication.

[101] Patient #2's next appointment, on June 14, 2016, was documented by a JURSI. Dr. Mohammed attended near the end of the appointment. The report included an assessment of "normal thyroid functioning" and a plan to discontinue Tapazole and check thyroid functioning in 5-6 weeks.

[102] Patient #2's next appointment, on August 4, 2016, "probably" included a stethoscope exam of her heart, to monitor the effects of discontinuance of Tapazole, which she had resumed

[24] Tab 9.

taking on her own after she became symptomatic following the discontinuance of the new medication. The report to G.P. following this attendance does not indicate a physical or thyroid examination because both were normal. The letter notes that she felt better since restarting Tapazole. It was not possible that he met Patient #2 at the reception desk and took her to the examination room; his receptionist does that. He denied shaking her hand for a long time, although he quite possibly may have touched her hand or forearm, testing her skin, to gain an appreciation of the skin texture for a patient with thyroid disease, whether the hand was vibrating, hot and sweaty, especially if he was thinking of early Graves' Disease based on the antibody negative in her case. He may or may not have told her that was what he was doing. The process of examination can start even with the gait of the patient when they walk into the office. He did not tell Patient #1 he was happy to see her. He had no reason to say that and can't justify saying it. He asks every patient what they do and where they live; "There's no sharp line between a physician and patient in a way for questioning. The questioning is some interlinking, but between privacy and disease that maybe affected each other…" He is not sure on which visit this occurred, but she said she was excited to go on vacation. On the August 4, 2016 attendance, he most likely asked her about her vacation. Her vacation would be of clinical relevance only if there had been an interruption of medication. He agreed that it was possible he asked if he could see her at work because he would not be surprised if he came across her "maybe every week or twice or three times a week" if she was working in a [redacted] in the area. He did not know she worked for a [redacted] until once in the reception area she pointed towards the office where she worked, across the street. Both the [redacted] and what he now knows was her office are in the same commercial complex. He probably placed the stethoscope down the top of Patient #2's dress, as she testified, and quite possibly placed it ever so slightly on her areola, accidentally. He does not remember but quite possibly touched her shin, knowing her antibodies were negative, to assess for Grave's Dermopathy, which can start with abnormality in the skin. Examination can be done with the doctor's thumb, index finger, or two or three fingers. While it is possible he touched her shoulder, he does not know why he would do so as he had no reason to do so.

Dr. Mohammed's testimony re patient N.R.

[103] No thyroid testing had been done by N.R.'s family physician for excessive sweating. On April 15, 2015, he discontinued the low dose of Tapazole he had put her on, as her symptoms had improved. Again, there was no record of a stethoscope examination. He possibly said words to the effect of "I'll take care of you; it's going to be all right," but he did not put his hand on her at all. He is in the file room with patients only rarely, for example when he gives them medication samples. He was never in the file room with N.R. His assistant sits at her receptionist desk, approximately 8 feet away. The file room has a window in the centre of the exterior wall and, unless the office is closed, the file room light is kept on. At the June 15, 2015, attendance, she did comment on him being married, in reference to his wedding ring. Dr. Mohammed did not wear a wedding ring then or at any time in his life. Nor did his wife. It was not the custom in the small village they are from to do so. He showed that there was no tan line or indentation where a wedding ring would go. What she said about telling him she had a boyfriend and Dr. Mohammed stepping back and saying "okay" did not happen.

Cross-examination

[104] Dr. Mohammed agreed that the following principles apply equally to an endocrinologist as to any other physician:

- Part of conducting a physical examination is explaining to the patient what is being done and why, to ensure that the patients understands and consents.
- It is appropriate to touch the patient only if necessary for a clinical examination.
- It is important to ensure respectful and professional communication. To seek out a personal relationship with patient would be a breach of professional boundaries.
- Maintaining professional boundaries is important, given what some may perceive as an imbalance in the doctor/patient relationship that can cause some patients to be vulnerable.
- Part of conducting a physical examination is recording its findings.

[105] He also agreed:

- Given that his letters to the family doctors constituted his entire record, it was important that they contain complete documentation of pertinent physical examination findings; his assessment of the patient; positive findings or important negative findings; the history taken; investigations ordered; and diagnosis or perhaps differential diagnosis.
- Typically, it is important to know the patient's pulse and blood pressure and to determine whether there were any thyroid bruits or if there is a big goiter and extreme hyperthyroidism (the latter did not apply to the patients here) and it is important to record the findings so that at the next visit he can compare.
- The objective of a stethoscope examination in the context of a thyroid examination, is to take the information gathered from listening to the heart with the rest of the information he has about the thyroid and its functioning. He does not typically listen to all four cardiac listening posts: he generally listens only to three that are almost in one location. The fourth is underneath the nipple. He doesn't always listen to the mitral area for the purpose of a thyroid examination in relation to the heart. He agreed that he should listen on at least one of the listening posts, as those are places where one is best able to hear the heart sounds. When doing a stethoscope exam, he is listening to identify the effect of abnormal thyroid function test and the heart.
- It is important to afford privacy when examining sexualized body parts.
- A woman's breasts are sexualized body parts and any chest auscultation is by necessity in the breast area. Stethoscope examinations of females should be done only if medically necessary. In auscultation above the breast tissue, one should try to avoid the densest part of the breast tissue because one cannot hear as well through it.
- Dr. Mohammed's receptionist is a registered nurse and eligible to act as a chaperone.

- He has 10,000 to 15,000 patients, seeing him every four to 6 weeks, every 3 months, or every year. Typically, he sees 15-20 patients a day. [25]He has no personal recollection of Patient #1 and is relying on his records and usual practice. As to Patient #2, although he is not sure when, he remembers her saying she was going on vacation, because she was so excited. The rest of his testimony about her is based on his usual practice. He palpates the thyroid the same way with his left hand and the right shoulder of every patient. He did not remember N.R. until he saw her at the hearing and has no memory of his specific interactions with her. He does not remember anything regarding the file room because he had no memory of her.

- He finishes his notes related to history, physical examination and plan that ultimately go into the consultation letter before he leaves the examining room following the patient visit. His receptionist, in conjunction with the EMR[26] he has inputted, prepares the actual letters. Rarely, he adds something that is missing or corrects these letters.

[106] Dr. Mohammed acknowledged that taking pulse and blood pressure would be important, yet no vital signs are recorded in the consultation letter he sent after Patient #1's July 7, 2016 visit.[27] He explained that this was because these were normal but agreed that there is a range of normal. He debated whether that means that on other occasions when it is recorded, it was not normal, saying that there is an electronic prompt and maybe he forgot to click it on that visit, but definitely any abnormal findings would be red flagged, and the patient informed. The September 10, 2014 consultant letter regarding N.R.[28] stated:

> Physical Examination: VS: BMI: 22.0, BP 120/70, H 62.00, P: 70/mon, W: 120 lbs. There is no thyroid enlargement. Her chest is clear. CVS (cardiovascular system) – NAD (no abnormality detected).

[107] Dr. Mohammed acknowledged that on this occasion he recorded the results of a stethoscope examination even though there was no abnormality, stating that this is because the patient came in with symptoms, not knowing what was causing them. The letter to the consultant following N.R.'s next visit, of October 1, 2014 also reported that her chest was clear, CVS, NAD.

[108] His typical practice regarding stethoscope examinations is to explain to the patient what he is going to do before he does it. Usually, the patient does not reply. Sometimes they will say to go ahead. He may not say that he is going to put his hand inside the shirt because it depends where he is going to put the stethoscope and it is the stethoscope that will contact their skin, not his hand. Rarely he comes up from the bottom of the shirt. (e.g. as with Patient #2). It is possible that in that instance he put the stethoscope at the lower ribcage, at the root of the

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[25] These numbers do not add up. If Dr. Mohammed has as few as 10,000 patients and sees as man as 20 daily, it would take 500 working days to see each patient more than once. Also, his testimony on the number of patients he sees daily does not square with that of his assistant.

[26] Electronic Medical Records

[27] Exhibit C-3, Tab 2, p. 4

[28] Exhibit C-3, Tab 15, p. 32

breast. In the examination of Patient #1, he does not remember how many places he moved the stethoscope to, or whether he was sitting or standing, but definitely he was on her right while she was sitting and the stethoscope was in the centre or maybe in the left when he put his hand, with the stethoscope, down her shirt, over the middle of the sternum. It was possible he asked her to lean forward. While palpating a patient's neck, his usual practice is to put his left hand on the patient's shoulder or behind their neck, because the thyroid and vocal cords are around soft tissue and you may not be able to palpate a nodule. Putting the hand there gives the patient some support. Asked about whether it was his current practice to brush a patient's hair away if it happens to be in the neck area, he has done about 20,000 thyroid examinations and if the hair is in the way, he brushes it away, only to make the view clear for him to palpate the thyroid. He acknowledged that he could simply ask the patient to move their hair out of the way. He acknowledged that on the August 18, 2016 visit with Patient #1, while he likely did a stethoscope exam, and the consultant letter reports blood pressure and pulse, there is no reference to the result of the stethoscope exam.

[109] Dr. Mohammed acknowledged that if the patient is wearing a very thin shirt, he may listen through the shirt. He was shown as an exhibit the shirt Patient #1 wore on August 18th and agreed it was a very thin fabric. Ideally the stethoscope should be in direct contact with the patient's skin, but a screening exam may be done over very light clothing especially if it does not create a scratching noise. He agrees that he told the Preliminary Inquiry Committee in April 2017 that most of the time if the clothing is thin, he just does it over clothing. He disputed that he was testifying differently at the hearing, saying he had no preference either way, that he would do whatever is most easily accessible. He would have compared his assessment with the previous assessment but acknowledged the previous one was not recorded.

[110] There was nothing in his reporting note about voice change, one of the reasons for referral, because he was not worried about it. The letter referred to her returning in 6 months, but the appointment card showed 3 months. He explained that he was going on holidays but had no explanation for why he did not change this appointment so that she came in a couple of weeks before his holidays.

[111] Nothing in his notes indicated that Patient #1 was unhappy when she left her August 18, 2016 appointment. He had not given her any bad news. She did not return to his office. His receptionist reminds patients two or three days ahead of appointments, by phone or mail.

[106] As to Patient #2's first attendance, on April 6, 2016, the consultant's letter[29] records pulse and blood pressure, even though they are in the normal range. He noted "no goiter," which indicates that he did a neck examination. He is almost certain he did a stethoscope examination, although nothing is recorded in the letter. He recalls Patient #2 introduced herself as a [redacted] (this is included in the Personal History available on the same date.) It is not unusual to have such discussions, to make the patient feel comfortable. There was also no physical examination recorded on the second visit, May 3, 2016.[30] Weight and height have to be recorded in the EMR, which then auto-populates for BMI. The letter summarizing the next

[29] Tab 7, p. 18

[30] Tab 9, p. 20

visit, June 14, 2016,[31] was prepared by a JURSI. Asked whether, on the fourth visit, of August 4, 2016, he recalled telling Patient #2 he had been thinking of her, he replied:

> Thinking about – about her case, it's a unique challenging case… not as a person. And she is not the first patient that even when I am on holiday, I may phone from overseas and say, what happened to Mrs. So-and-so regarding so-and-so?

[107] Dr. Mohammed was asked about his letter to the College of October 27, 2017 which stated:

> I do not remember asking her whether she was happy to see me. I have no reason to say I did not.

He testified that he possibly may have said that and agreed that there would be no justification for saying it.

[108] Dr. Mohammed acknowledged that nothing in his letter reporting on the fourth visit, of August 4, 2016,[32] states that he had checked Patient #2's skin. Asked whether in examining a patient's skin he should tell her what he was doing and why, he replied, "In relation to the thyroid, yes." He knew she was a [redacted] but did not know she worked for [redacted]. There was no record of vital signs such as blood pressure and pulse and no record of examining her for edema. In his letter to the College of October 27, 2017, he stated, "I do not recall touching her right shin or knee." Having testified in chief that if he touched her areola with the stethoscope, it was accidental, he acknowledged that this would not be an appropriate place to listen to the heart and even if the patient is clothed, he knows where the nipple is and the general area of the areola. He did not see anything to suggest she was not happy when she left that appointment: he had not given her any bad news and nothing happened that he thought would have upset her. She did not return after her August 4, 2016 visit.

[109] As to N.R., the letters of September 10[33] and October 1, 2014[34]do record a normal CVS exam—other examples of recording a CVS exam even though no abnormalities were detected. The letter of November 11, 2014,[35] completed by the JURSI, contained quite a bit more information, even though the CVS exam was normal. His letter reporting on the April 15, 2015 visit[36] shows no record of a chest examination, blood pressure, or pulse. He had testified in chief that he did not touch N.R.: in cross-examination he said he had no recall of that attendance, but he had no reason to touch her and certainly that was not part of the physical examination. He acknowledges that it would be inappropriate to ask to see a patient socially.

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[31] Tab 11, p. 24

[32] Tab 13, p. 27

[33] Tab 15, p. 32

[34] Tab 17, p. 35

[35] Tab 19, p. 37

[36] Tab 21, p. 41

On her last attendance on June 15, 2015,[37] he knows of no reason why she would be upset. She did not return to his office after that date.

[112] Responding to questions from the physicians on the panel, Dr. Mohammed testified that if he had five appointments with a patient, he would listen five times "to see if there is any change in the rate of the intensity of the heart sounds or not." He does not put his hand on a patient's shin in every case, but only where he is looking for non-pitting edema in relation to Grave's Disease. If he is looking for the effectiveness of the thyroid hormone on the body generally, he can do it in the hand or in the arm.

Evidence of Brenda Craig

[113] Ms. Craig, Dr. Mohammed's office administrator since 2001, testified by video link. She graduated as an LPN in 1987 but no longer works as such. She enters the file room 25-30 times a day. While seated at her desk, she can hear what's going on in the file room, where the lights are on all day during office hours. They see 20-40 patients daily. New patients are about 30, review patients are about 15 to 20. When patients arrive, she checks their papers, health cards, and takes their weight. When the examination room door is open, she takes the patient in.and enters the information on the examination room computer. When in the examination room next door, or at her desk, she can hear people speaking but not the full conversation. She hears better if the examination room door is open. She stays in the examination room as a chaperone during appointments if patients request this, which has happened roughly two dozen times. Most often, there are patients in both examination rooms at the same time. When the appointment is finished, the doctor brings the patient to her desk and tells her when to book a return. She processes lab requests and issues appointments for the next visit. She does not recall a patient coming to her in distress after an appointment. She has never seen Dr. Mohammed wear rings or jewelry. She does not remember Patient #1 or Patient #2 but remembers a patient telling her she worked with a [redacted] across the street, in the context of scheduling another appointment, as it was easy for the patient to come in.

[114] In cross-examination, Ms. Craig agreed that while she is entering EMR information in the examination rooms, she is not at her desk, or may at times use the washroom or take a break. The office is busy. Sometimes she passes patients in the hall. She notes in the EMR when a patient does not return for a follow-up appointment and notifies the referring physician.

Evidence of Dr. Margaret England

Direct Examination

[115] With the consent of the College, Dr. England was deemed qualified to give expert opinion evidence on the standards of practice of an endocrinologist, including stethoscope examination, assessment and treatment. She is currently licensed to practice in Manitoba (endocrinology) and in Ohio (internal medicine and endocrinology). She received her MD from the University of Ottawa in 1978, and completed her residency in Internal Medicine at the Good Samaritan Hospital in Phoenix in 1982 and her Fellowship in endocrinology and metabolism at

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[37] Tab 23, p. 44

UCLA in 1985. Since 1985, she has been a member of the American Thyroid Association (whose objectives are research and publishing in the field of thyroidology: they write the guidelines followed by the Canadian Thyroid Association, and the Endocrine Society, which publishes the journal *General Clinical Endocrinology and Metabolism*.) From 2000 to 2012 she was an expert reviewer for the California Medical Board, which reviews complaints against physicians, to protect the public. She was an assistant clinical professor of endocrinology at UCLA from 1985 to 2011. She is a Fellow of the American College of Endocrinology (FACE), which focusses on making clinical guidelines. She was qualified to give expert evidence in endocrinology in court in the United States. There are no differences in standards between the United States and Canada.

[116] Endocrinology is the study of the function of, and disorders associated with, chemicals made by a gland in one part of the body that affect the function of every other cell in the body. Every cell is like a factory: a hormone can affect what products get into the factory; what products are released; how fast the factory works; and whether the factory will be sensitive to other things in its environment. Thyroidologist is another term for someone who is accredited in internal medicine and endocrinology.

[117] There are differences between the standards of practice for an endocrinologist examining a patient and those of other branches of the medical profession. Other physicians are primarily engaged in screening for potential thyroid problems. Because the thyroid affects every function of every part of the body, the specialist looks at a patient very actively, subtly putting a number of pieces of information together even as the patient walks through the door.

[118] There are no specific standards for endocrinologists as to how and when to conduct a stethoscope examination of a patient's heart. A stethoscope exam is done as part of a thyroid exam, to help the physician put together pieces of a puzzle. For example, the thyroid hormone effect can cause a rapid flow of blood through heart valves, which could cause a murmur. But more often it is done to learn if the patient has structural heart disease because a hyperdynamic heart can make the difference between increasing or decreasing medication.

[119] Dr. England never has the patient disrobe for a stethoscope exam of the chest: she just sticks the stethoscope up or down, depending on the clothing. She lifts up the shirt and if there is a bra, lifts it up, "stick my stethoscope somewhere and take a listen." If she needs to move it, she'll move it. An endocrinologist conducts a more extensive stethoscope examination on the first visit, as lab tests are not reliable. There are many reasons to do such examinations.

[120] Endocrinologists do not place the stethoscope over the four cardiac listening posts: that is a cardiac exam, where the focus is on specific maneuvers to investigate whether there is valvular disease. A stethoscope examination by an endocrinologist can be done with the patient sitting on a chair or lying on an examining table. It is not standard practice for an endocrinologist, before conducting a stethoscope examination, to tell the patient what they are going to do. She would just tell the patient "I need to check you right now," and then would feel the patient's neck. She would also have them drink water as the thyroid moves with swallowing. There are exceptions when doing a male or female genital examination or an intimate exam of the breast where the whole breast is palpated. But when the patient is not disrobed, it is not an issue, since she is not touching them with her hands. It is not a concern for an endocrinologist to place a hand with the stethoscope down the front of the patient's shirt and place it on her cleavage near the sternum between her breasts, as that is where the heart is.

Leaning forward is not a concern with reference to the standards of practice of an endocrinologist, because any type of clothing that touches the tubing of a stethoscope can interfere with sound. If the patient leans forward, the fabric falls away. She does not use a stethoscope over clothing as there is too much sound: it has to be against the skin.

[121] Dr. England was asked about an endocrinologist resting a hand on a patient's shoulders, brushing the hair aside and then palpating the neck. She said she normally brushes a patient's hair away herself because if the patient does it, the neck muscles get tight and patients do not put the hair where she wants it. She examines posteriorly, but if examining anteriorly, one would not rest the hand on the shoulder, but instead would use it to stabilize the patient. Thyroid and neck palpations are usually done at every visit. After physical examinations, Dr. England does not specifically tell patients what has been found, except indirectly, in providing recommendations.

[122] It is not standard practice for an endocrinologist to document the results of any physical examination during an attendance unless the physical examination changed the planned course of action.

[123] A stethoscope exam was medically indicated at Patient #1's first visit because she had discontinued Tapazole, which she had been on for years; one would want to see if she was relapsing. She would have expected Dr. Mohammed to perform a stethoscope exam on the following visits.

[124] Dr. Mohammed putting his hand on Patient #2's forearm without advance discussion could be part of a thyroid exam, although context can make a difference. "We need to see the arm. So, if he didn't say anything to her and just started feeling her, that would be disturbing." By the fourth visit, if the patient was sitting in the chair in the examining room with one leg crossed over the other and Dr. Mohammed put his hand on her shin below her knee, there was a medical indication for doing so. She had stopped the medication that slows down the thyroid on her own and had to restart it once she saw Dr. Mohammed. One would want to look for clinical indications that she was hyper or hypo. Becoming hypo could cause a spongy, doughy sensation on the legs and one can get edema. A physician doesn't need to be looking at the skin to make this tactile assessment.

[125] It would not cause her concern if the stethoscope came into light contact with the upper part of the areola region upon first placement, because the physician is not looking and it is covered by clothes. Regarding the August 4, 2016 exam, for the reasons given earlier, she would not expect an endocrinologist to record the results of a stethoscope examination in this situation. A stethoscope exam was clinically indicated because Patient #2 had clinically become hyperthyroid again.

[126] Discussing a patient's vacation can be routine, to give the physician an idea of what is going on, because thyroid dysfunction can impact behavior. And there would be a clinical indication for asking this patient about what she does at work. It is all part of putting together how to interpret the patient's fatigue.

Cross-examination

[127] Dr. England was asked, regarding Patient #2, if it was appropriate to place the stethoscope on her left breast in the areola region. She replied, "You don't exactly know where it's going… you're usually not looking at the breast"… "You're putting the stethoscope in sort

of blind because you want … to get it to a spot on the chest where you can hear the heard sound clearly because you are looking at the character, not trying to characterize the flow through a heart valve…. So when you put it down there, you don't exactly know where the areola is." She acknowledged that there can be quite a bit of tissue between the areola and the chest wall.

[128] Dr. England acknowledged that a breast is a sexualized body part. She debated whether some women could be vulnerable to a male physician sticking their hand down their shirt and not knowing where the breast is, or where is he putting his stethoscope. She denied that it was the physician's responsibility, even when he is putting the stethoscope on the patient, to have some idea of where they are putting the stethoscope in this situation. "You might land on a place where you can listen adequately and if not, you move the stethoscope."

[129] Regarding touching the skin as part of an examination for pitting edema on the shin, Dr. England agreed that you need to press either the thumb or the fingertips into the tissue to see how it responds, and not just rest one's hand there.

G. LEGAL ISSUES AND ANALYSIS

e) General Legal Principles in Professional Regulatory Proceedings

[130] The principles of law applicable to hearings before discipline committees were set out in *Green v. The College of Physicians and Surgeons of Saskatchewan*:[38]

- The College has the burden of proving the case on a balance of probabilities;[39]
- Each member of the Discipline Committee is expected to apply his or her specialized knowledge in assessing the evidence before the Discipline Committee;[40] and
- What is unprofessional conduct is left to the standards of the medical profession to determine.[41]

[131] Dr. Mohammed submits that to qualify as unprofessional conduct, the impugned conduct must be "sufficiently serious" and a technical or inadvertent breach may not reasonably warrant disciplinary action.[42] He further submits that the standard of care expected of a physician has never amounted to perfection.[43] We agree with these basic principles.

[132] Finally, in terms of what must be proved, it is worth stating that:

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[38] (1988), CanLII 3238

[39] Para. 13

[40] Para. 21

[41] Paras. 10-12

[42] *Huerto v. College of Physicians and Surgeons of Saskatchewan*, 2004 SKQB at 24 and *Merchant v. Law Society of Saskatchewan*, 2002 SKCA 60.

[43] *Carlsen v. Sutherland*, 2006 BCCA 214 at paragraphs 13-15, affirming the principles from *Wilson v Swanson*, [1956] SCR 804

(a) The Committee must determine whether the evidence has demonstrated on a balance of probabilities (to a 51% likelihood) that Dr. Mohammed did what is alleged in the charges; and that his conduct was unbecoming, improper, unprofessional or discreditable;

(b) It is not necessary for the College to prove every element of the charge: if the Committee determines on a balance of probabilities that Dr. Mohammed has committed any of the allegations, it can find him guilty of unprofessional misconduct.

f) General Principles in the Assessment of Credibility and Reliability

[133] There is no "smoking gun" in this case. There were no independent eyewitnesses to the events themselves, so the credibility and reliability of witnesses is squarely in issue. For reasons that follow, we do not propose to ascribe any weight to the testimony of N.R. This leaves only the testimony of the two complainants and the witnesses that each spoke to following their appointments; their medical records; and Dr. Mohammed. Dr. Mohammed testified to remembering nothing about these two patients except that Patient #2 was excited to go on holidays and was a [redacted]: the rest of his testimony was said to be derived from his usual practices versus actual memory of events. His receptionist provided some evidence as well, about his office routines. While not related to credibility of the main participants, the conflicting evidence of the two experts must be considered as well.

[134] The assessment of credibility requires consideration not only of the appearance of telling the truth but also of opportunities for knowledge, powers of observation, judgment, memory, ability to describe clearly and other factors:

> In short, the real test of the truth of the story of a witness… must be its harmony with the preponderance of the probabilities which a practical and informed person would readily recognize as reasonable in that place and in those conditions."[44]

[135] In proceedings under the *Medical Profession Act, 1981*, as in every civil proceeding, it is necessary to assess both the credibility and the reliability of each witness. By "credible" we mean: was the witness honestly trying to tell the truth? By "reliable" we mean: was the witness able to give accurate testimony? The distinction between those two concepts was discussed by the Ontario Court of Appeal in *R. v. S. (W.)*:[45]

> We all know from our personal experiences as trial lawyers and judges that honest witnesses, whether they are adults or children, may convince themselves that inaccurate versions of a given event are correct and they can be very persuasive. The issue, however, is not the sincerity of the witness but the reliability of the witness' testimony. Demeanour alone should not suffice to found a conviction where there are significant inconsistencies and conflicting evidence on the record.

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[44] *Farnya v. Chorney*, [1952] 2 D.L.R. 354 (B.C.C.A.), at pp. 356-7

[45] (1994), 90 C.C.C. (3d) 242 (Ont. C.A.), at p. 250; leave to appeal to S.C.C. refused 93 C.C.C. (3rd)

[136] Some factors we may look at, to determine whether we can rely on a witness's testimony, include:

- its consistency over time—whether the story changes significantly between tellings;
- its consistency with other known facts; and
- whether the story told by the complainant makes sense in the context of what a reasonable and informed person would recognize as likely, in that place and in those conditions.

[137] There is a helpful discussion of a methodology for assessment of credibility by the British Columbia Human Rights Tribunal in the decision *Brar and others v. B.C. Veterinary Medical Association and Osborne.*[46]

[138] As observed by the Saskatchewan Court of Appeal in *Shamsuzzaman v. CPSS,*[47] an administrative tribunal is obliged to consider the whole of the evidence to decide whether the complaint has been proven. To that end, the Committee must be careful not to determine the credibility of the complainants without first reviewing the evidence of Dr. Mohammed. Also, the Committee must be mindful that it is not limited to choosing between the versions put forward by the complainants or by Dr. Mohammed: If a third version is available on the facts, it must be considered.

[139] This case readily allows for some misinterpretation of events, which we will address below. At the same time, both complainants were unshaken in their testimony on the key issue of Dr. Mohammed's conduct. They were adamant that Dr. Mohammed engaged in inappropriate personal conversation; touching and examinations that made them uncomfortable; in the case of Patient #1, disconcerting behaviour when she attempted to leave the examination room on her last appointment; and in the case of Patient #2, a request by Dr. Mohammed that he visit her at her workplace.

[140] Dr. Mohammed was adamant that these culminating incidents did not occur. This is a fundamental issue, because if these culminating incidents are found to have been proven, they frame the interpretation of the balance of the conduct complained of. There is no basis for misinterpretation here—these incidents are either proven to have occurred or they are not. Given the contradictory testimony, the Committee must consider the surrounding circumstances to determine whether either version of events is, in the words of *McDougall*, "inherently improbable," bearing in mind that the burden remains on the College to prove the essential ingredients of the charge, not on Dr. Mohammed to disprove anything.

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[46] (No. 22), 2015 BCHRT 151, especially at paragraphs 78, 79, 80 and 84

[47] 2011 SKCA 41

g) Ought the Committee to consider the patients' subjective perception of Dr. Mohammed's actions in determining whether he has committed sexual improprieties?

[141] Dr. Mohammed relies on *Hanna v. Council of College of Physicians and Surgeons of Saskatchewan*,[48] in which Dr. Hanna was convicted by the Discipline Committee of nine counts of misconduct, one of which involved touching a patient's buttocks and stating that she was putting on weight. Dr. Hanna's appeal, brought on several grounds, was allowed on grounds that the Discipline Committee's decision was based on the patient's subjective feelings as opposed to an objective assessment of conduct. Justice Baynton stated:

> [20] The disciplinary hearing committee erred in concluding that the subjective perception of the complainant, without regard to what Dr. Hanna might have intended or without regard to objective considerations, was determinative of the issue. A conviction for a disciplinary offence of a sexual nature will in most cases result in the suspension of the physician. **If convictions could be based on the subjective feelings of the complainant alone, physicians would be placed in an untenable position. They could be suspended from practice for no other reason than the unreasonable perceptions of an overly sensitive patient**.
>
> [21] A review of the Bylaw indicates that an inherent aspect of the definition of the terms "sexual impropriety" and "sexual violation" is an objective assessment of the conduct in question. See s. 51(1)(g)(viii) for example. **The subjective perceptions of a complainant are important, but they are not determinative of the nature of specific conduct unless the perceptions are reasonable.** Objective considerations as well as subjective ones are involved in determining the nature of the conduct in issue in any given situation. All the circumstances surrounding an alleged incident must be taken into account before it can be determined whether it constitutes "sexual impropriety" or a "sexual violation". **The complainant's subjective perception of an incident, unsupported by reasonable grounds, cannot alone determine the nature of the conduct associated with the incident, nor can it reasonably support a conviction for "sexual impropriety" or "sexual violation" under the Bylaw.**
>
> [22] **Nor does the broad discretion given to the disciplinary hearing committee by s. 46(o) of the Act permit it to base a conviction on the complainant's perception alone.** Under this provision the disciplinary hearing committee may find a member guilty of unbecoming, improper, unprofessional or discreditable conduct if the member does or fails to do anything "where the discipline hearing committee *considers* that action or failure to be unbecoming, improper, unprofessional or discreditable." The term "considers" denotes that it is the disciplinary hearing committee itself that must determine whether the conduct complained of is improper. **A disciplinary hearing committee performs a judicial or quasi-judicial function and any discretion given to it must be exercised judicially. It would fail to do so if it simply accepted the perception of the complainant without an independent assessment of all relevant factors**. As well, the disciplinary hearing committee would lose jurisdiction over the

[48] [1999] 179 Sask. R 181 (Sask Q.B.)

> issue if it abandoned its function by leaving it up to the complainant to determine the very issue the committee was struck to decide.[49]
>
> [Emphasis added]

[142] Dr. Mohammed submits that Patient #1 and Patient #2 misinterpreted his stethoscope/physical examinations and that the *Wooley* case cautions that such misperception may impact their perceptions of subsequent interactions with him.

[143] The College relies on *Pillay v CPSS* (2016), in which the Discipline Hearing Committee accepted that an inference could be drawn from the complainant's state of mind after the appointment, that something must have happened to upset her. Dr. Pillay appealed the Committee's decision to the Court of Queen's Bench, which upheld the Committee's decision.**[50]** The court rejected Dr. Pillay's argument that the Committee took the complainant's upset state as virtually conclusive proof that he had hugged her and asked to kiss her. The court noted that the Committee considered this among many other factors in determining the patient's credibility and reliability, not as outright proof. The Court noted, however, that the Committee was indeed influenced by the patient having been upset after the appointment, as is made clear from the following passage from the Committee's decision referred to by the Court:

> [66] There was no negative diagnosis or other obvious reason for her to break down in her car after this office visit apart from the inappropriate conduct she described. That this previously appreciative, grateful patient became uncharacteristically and seriously upset after leaving her doctor's office **strongly suggests** that something significant and inappropriate had happened. (emphasis added by Court)

[144] The court in *Pillay* wrote that such a consideration can be appropriate, citing Justice Fuerst in *R v Lindsay*,**[51]**as only one of the factors considered in determining the patient's credibility and reliability. The court in *Lindsay* put it this way:**[52]**

> I agree that it can be dangerous to place weight on a witness's demeanor when he or she testifies. It is well-established, however, that evidence of a complainant's emotional state after an alleged offence may constitute circumstantial evidence confirming that the offence occurred,

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[49] Dr. Mohammed relies on a similar analysis in *Wooley v. College of Physicians and Surgeons of British Columbia*, [1996] 6 WWR 716, where the court commented to the effect that the Committee must be particularly careful in assessing the perceptions of the complainant because of its finding that she had misconceived the activity of the doctor in his conduct of the physical examination. Dr. Wooley appealed a conviction of one count of unprofessional conduct for unprofessional language with a sexual connotation during his dealings with the complainant.[49] The Court allowed the appeal, holding that the conviction was not sufficiently proven, as all three counts were based on the complainant's perception of Dr. Wooley's conduct.

[50] *Pillay v CPSS*, 2018 SKQB 54, especially at paras. 15-17

[51] 2005 CanLii 25240 (ONSC)"

[52] At para. 159

> depending on the circumstances of the case, including the temporal nexus to the alleged offence and the existence of alternative explanations for the emotional state.

[145] The Committee accepts the rationale provided by Dr. Mohammed in support of a cautionary approach: we agree that it would not be appropriate to base a conviction solely on the subjective feelings of a complainant. An objective assessment is required. At the same time, we also agree with *Hanna*, *Pillay*, and *Lindsay* that the state of mind of the patients contemporaneous with the alleged incidents, while not determinative, is nevertheless important in relation to the credibility and reliability of their testimony.

h) **Admissibility of evidence of Ms. M and Ms. B**

[146] Dr. Mohammed submits that the evidence of Ms. M and Ms. B should either not be admitted or should be given no weight. He submits that their evidence violates the rules against hearsay, oath-helping, and prior consistent statements, and is irrelevant to the issues raised by the charges.

[147] On the issue of hearsay, Dr. Mohammed submits that the traditional law of hearsay also extends to out-of-court statements made by a person who does testify in legal proceedings when the out-of-court statement is tendered to prove the truth of its contents.[53] Even if the hearsay falls within an exception to the general rule, the exception must be supported by the indicia of necessity and reliability in accordance with the principled approach.[54]

[148] On the issue of oath-helping, Dr. Mohammed submits that evidence adduced solely to bolster a witness's credibility will generally be excluded,[55] relying on *R. v Llorenz*,[56] where the Ontario Court of Appeal summarized the law as follows:

> [27] The rule against oath-helping prohibits the admission of evidence adduced solely for the purpose of proving that a witness is truthful. **The rule applies to evidence "that would tend to prove the truthfulness of the witness rather than the truth of the witness's statements.**" [citation omitted]
>
> [28] The line to be drawn when evidence is considered to be oath-helping is not always clear. There is a distinction to be made between (1) evidence about credibility (i.e. in my opinion the witness is truthful), which is inadmissible and (2) evidence about a feature of the witness's behaviour or testimony, which may be admissible even though it will likely have some bearing on the trier of fact's ultimate determination of the question of credibility. [citation omitted]

[149] The Court in *Llorenz* went on to note that oath-helping evidence may be admitted if it has another legitimate purpose. Dr. Mohammed argues that the College has not identified a legitimate purpose for tendering this evidence, which cannot be accepted as evidence that

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[53] *R v Khelawon*, (2006) 2 SCR 787 at para 47

[54] *R v B (K.G.)*, [1993] 1 SCR 740 at para 108 – see *R v Couture*, 2007 SCC 28 at para 112, for the definition of necessity

[55] *Beland v R.*, [1987] s SCR 398 at para 67.

[56] 2000 Canlii 5745

would tend to prove the complainants' truthfulness, and on that basis, risks distorting the fact-finding process.

[150] Dr. Mohammed relies on *R. v Ward*,[57] where the Newfoundland and Labrador Court of Appeal held that a victim's prior consistent statement reporting a sexual assault to another could not be used to corroborate the victim's testimony that the sexual assault occurred. He argues that whether Patient #1 or Patient #2 was upset does not make the facts supporting the charges any more or less likely, nor does it make the complainants' testimony any more truthful or credible. Ms. B and Ms. M's evidence does not provide any value or content that cannot come directly from the complainants' testimony and therefore lacks probative value and is prejudicial in these proceedings.

[151] The College submits that while prior consistent statements are generally understood to be inadmissible, there is a well-recognized exception if the statements are being proffered as part of the narrative of the case, as set out by the Saskatchewan Court of Appeal in *R. v Louie*:[58]

> [12] There is no issue of recent fabrication and the Crown relies on admissibility as part of the narrative. However, it is not the admissibility of the statement but rather its use which is in issue. The prior consistent statement may be used in assessing the truthfulness and credibility of the witness but it cannot be used to corroborate the allegation that an offence was in fact committed. A prior consistent statement which is admitted under one of the exceptions is not admissible for the truth of its contents. The fact a complainant stated in the past that a crime had been committed does not prove that a crime has, in fact, been committed (see *R v Bisson*, 2010 ONCA 556 (CanLII), 258 CCC (3d) 338).
>
> [13] The trial judge's statement at para. 55 of the judgment can be interpreted in two different ways: either the complainant was credible because her prior disclosure was corroborated by her mother (a permissible use) OR the trial judge found her allegations were more credible because she told her mother about the sexual assault years prior to reporting the matter to the police. An admissible prior consistent statement may only be used to bolster the credibility of the person who made the statement. It cannot be used to bolster the credibility of the contents of that person's in-court testimony.
> [emphasis added]

[152] To decide the legal issues raised in this regard, we first find the following facts to be proven:

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[57] 2008 NLCA 38

[58] 2014 SKCA 107 (Can LII), para 10-13; see also *R. v Dinardo*, 2008 SCC 24, where, after stating the general rule that prior consistent statements are inadmissible, the court stated: "[37] In some circumstances, prior consistent statements may be admissible as part of the narrative. Once admitted, the statements may be used for the limited purpose of helping the trier of fact to understand how the complainant's story was initially disclosed…"; and, at para [38], quoting from to *R. v. G.C.* [2006] O.J. No. 2245: "…the evidence can be supportive of the central allegation in the sense of creating a logical framework for its presentation… and can be used in assessing the truthfulness of the complainant…" *In appropriate cases, the way the complaint comes forth can, by adding or detracting from the logical cogency of the child's evidence, be a useful tool in assisting the trial judge in the assessment of the child's truthfulness*…"

- Ms. B received a phone call from Patient #1 immediately after she had left Dr. Mohammed's office on August 18, 2016. Patient #1 was upset and tearful and said that she felt she had been assaulted by Dr. Mohammed.
- Ms. M had a discussion with Patient #2 immediately upon Patient #2's return to the office after her August 4, 2006 attendance with Dr. Mohammed. Patient #2 was very upset and said she had been subjected to inappropriate conduct by Dr. Mohammed and felt it was necessary to report the conduct.

[153] We agree with Dr. Mohammed that to take the statements of Patient #1 and Patient #2 to Ms. B and Ms. M as proof of their contents would clearly violate the hearsay rule.

[154] However, having considered the authorities and submissions, we are of the view that the testimony of Ms. B and Ms. M regarding prior consistent statements of the complainants is admissible on a number of grounds, specifically: to rebut any suggestion of recent fabrication; to show consistency over time in the versions of events put forward by the complainants; and, most importantly, as an application of the narrative evidence exception to the rule against previous consistent statements. Prior consistent statements can be used to establish the state of the declarant's mind: *R. v M.C.*[59]

[155] The evidence of Ms. B and Ms. M can properly aid in our assessment of the credibility of Patient #1 and Patient #2. Dr. Mohammed identified no reason for Patient #1 or Patient #2 to be upset following their final appointments. According to his evidence, they were not upset when they left his office.

[156] The evidence of Ms. B and Mr. M as to what they were told by Patient #1 and Patient #2 respectively, is admissible as narrative evidence to establish the state of mind of Patient #1 and Patient #2, the chronology of what occurred after their appointments, and what they described as the reason for their state of mind. The key here is the link between their emotional state and what was said about the cause of this. We cannot use this evidence to determine the truth of the words spoken to Ms. B and Ms. M. However, this evidence can assist us in assessing the evidence as to the complainants' states of mind, and in determining their credibility.

[157] We conclude that the evidence of Ms. B and Ms. M is admissible as part of the narrative to describe what the complainants were experiencing and why they were so upset. While far from decisive, we are of the view that an inference can and should be drawn that the emotional upset was caused by something that happened during the complainants' last appointments with Dr. Mohammed.

i) Should the Committee consider the testimony of N.R. as Similar Fact Evidence?

[158] The College submits that the Committee ought to receive the evidence of N.R. as similar fact evidence supporting the probability that Dr. Mohammed did what the two complainants allege. The College asserts that the current judicial approach to admission of similar fact

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[59] 2014 ONCA 611

evidence is to consider whether the benefit of admitting the evidence outweighs the risk of admitting it.

[159] Similar fact evidence is presumptively inadmissible: the onus is on the prosecution to establish on a balance of probabilities that in the particular case the probative value of the evidence in relation to a particular issue outweighs its potential prejudice and justifies its reception.[60]

[160] The Supreme Court of Canada has described the task of the decision-maker as follows:[61]

> … the strength of the similar fact evidence must be such as to outweigh "reasoning prejudice" and "moral prejudice". The inferences sought to be drawn must accord with common sense, intuitive notions of probability and the unlikelihood of coincidence. Although an element of "moral prejudice" may be introduced, it must be concluded by the trial judge on a balance of probabilities that the probative value of the sound inferences exceeds any prejudice likely to be created.

In that case, the factors connecting the similar facts to the circumstances of the charge were:

- proximity in time of the similar acts;
- extent to which the other acts are similar in detail to the charged conduct;
- number of occurrences of the similar acts;
- circumstances surrounding or relating to the similar acts;
- any distinctive feature(s) unifying the incidents;
- intervening events; and
- any other factor which would tend to support or rebut the underlying unity of the similar acts.

[161] While noting that not all factors will be present—or necessary—in every case, the Court also set out countervailing factors that have been found helpful in assessing prejudice:

- the inflammatory nature of the similar acts;
- whether the Crown can prove its point with less prejudicial evidence;
- the potential distraction of the trier of fact from its proper focus on the facts charged; and
- the potential for undue time consumption.[62]

[162] The College submits that true prejudice arises only if it produces an unfair hearing for the accused person. The fact that admissibility of similar fact evidence will strengthen the case

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[60] *R v Doodnaught*, 2017 ONCA 781, paras 147-153. See also *OCPS v Peirovy*, 2018 ONCPSD 6

[61] *R. v. Handy*, 2002 SCC 56 at paras 42 and 82

[62] See also, *The Law of Evidence in Canada*, 5th Ed.[62], where the learned authors state: "…The theory of admissibility in true similar act cases turns on the improbability of coincidence."

against the accused by itself is not prejudice. Prejudice arises if the evidence is used to establish that the person is of bad character and therefore guilty, rather than to prove that the person did the alleged act. The College cited a case where similar fact evidence was admitted in like circumstance and upheld by the courts.[63] Similar fact evidence was admitted to establish a physician's pattern of approaching vulnerable female patients and attempting to interest them in a personal relationship.

[163] Dr. Mohammed submits that the evidence does not meet the test for the admissibility of similar fact evidence. Following the three-step process outlined in *Handy*[64]-- determine the probative value of the evidence; determine its prejudicial effect; then weigh one against the other—he argues as follows:

- N.R.'s testimony is of little probative value because:
    - The College has not identified an issue to be addressed by this evidence, beyond a vague suggestion of bad character or general predisposition;
    - The substance of N.R.'s testimony is not sufficiently connected to the acts charged because she saw Dr. Mohammed one to two years before Patients #1 and #2, and the events she described were not sufficiently similar to the acts charged;
    - N.R.'s evidence is unreliable, given that she fabricated her testimony about the wedding ring.
- N.R.'s testimony will have prejudicial effect because:
    - It aims to support a finding of guilt based only on "bad character";
    - It may confuse issues for the decision maker; and
    - If admitted, Dr. Mohammed will be confronted with allegations that are not the subject of a charge and to which he has not had a reasonable opportunity to respond.
- Weighing the testimony's probative value against its prejudicial effect: Dr. Mohammed says that admitting N.R.'s evidence poses a serious risk of causing distraction in the hearing, which should focus on the two charges against Dr. Mohammed, and this risk far outweighs the little probative value that may result.

[164] We now consider these submissions in the context of evaluating N.R.'s testimony about the comments she attributed to Dr. Mohammed at the end of their last appointment, to the effect that "We have something, don't we" and asking for her telephone number. This is because her testimony on these issues was so firmly anchored in her adamant recollection of expressing her concerns about him being married, due to seeing his wedding ring. Based on Dr. Mohammed's evidence on this point, which we accept and which was corroborated by his assistant, we are unable to accept N.R.'s evidence on what would have been a central point to her testimony.

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[63] *Dhawan v College of Physicians and Surgeons of Nova Scotia*, [1998] N.S.J. No 170 at paras 63, 64, and 74

[64] *Handy*, paras. 98-101, *R v Clottey*, 2018 ONCJ 536 at para 855

Second, we do not find it probable that the light in the storage room was off during office hours, given the usage of that room by physicians from other clinics and Ms. Craig's testimony. In the end, N.R.'s evidence was far from cogent, persuasive and compelling on this point and we do not accept it. Having come to this decision, we do not accept, as Dr. Mohammed contends, that N.R. fabricated her testimony on this point. There was no evidence that she intended to deceive and no suggestion of a reason why she would do so. We find that she firmly though incorrectly believed her memory of a wedding ring to be true. Still, it would not be safe to rely on her testimony as similar fact evidence in this case.

j) Should the Committee accept the evidence of each complainant as similar fact evidence supporting the evidence of the other?

[165] The College asks the Committee to consider the evidence of each of the two complainants in evaluating the evidence of the other. Dr. Mohammed makes the same assertions as he did in respect of the evidence of N.R.

[166] A central issue in this case is whether Dr. Mohammed undertook his contact with Patient #1 and Patient #2 for a medical purpose. The College asks us to infer from "inter-charge" similar fact evidence that Dr. Mohammed has a propensity to use patient examinations as an opportunity to have inappropriate contact with patients. Dr. Mohammed asserts that their evidence, when considered with Dr. England's expert evidence regarding the standard of practice of endocrinologists, leads to the opposite inference—that he followed his standard practice during the examinations, which itself was in accordance with the standard expected of an endocrinologist.

[167] Dr. Mohammed cites *Clottey*, *supra*, where the court dismissed the Crown's application to admit inter-charge similar fact evidence to infer that the accused had a propensity to use the opportunity of breast and pelvic examinations of female clients for sexual gratification. The court found that the similar fact evidence had little to no probative value in relation to the inference that the Crown sought to show:

> [850] Doctors tend to conduct themselves in accordance with their standard routines or practices. What one would expect where that was happening would be to have complainants making somewhat similar observations about those practices. Intimate examinations can be uncomfortable at the best of times, particularly vaginal examinations. Add the element of unfamiliarity with a technique used, some possible unintended discomfort in some cases, successive media reporting that led three of the six complainants to file their own complaints, and the groundwork was laid for what happened in this case.
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> [853] Similarities in descriptions and perceptions would be expected to occur when a doctor employs a similar technique of examination for patients generally. Indeed, it would be surprising in the extreme, if similarities were *not* described. That does not mean, however, that the noted similarities suggest or demonstrate a pattern of wrongful, disreputable or criminal behaviour.
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> [854] The key question in the analysis is: "What inferences does the proposed evidence support"? As stated by Binnie J. in *R. v. Handy*, "the inferences sought to be drawn must accord with common sense, intuitive notions of probability, and the unlikelihood of coincidence".[527] These criteria do not support any inference of sexualized touching in this case. Common sense and probabilities support medical, rather than sexual, touching.

[168] Dr. Mohammed asserts that the similarities between the examinations of Patient #1 and Patient #2 rob the evidence of any distinctiveness and probative value. The examinations were

routine elements of an appropriate examination of an endocrinologist, as explained by Dr. England. The aspects of the complainants' evidence regarding the routine portions of their examinations (e.g., not being asked to disrobe and the method of the stethoscope examination) are expected in an examination by an endocrinologist. These circumstances are like those in *Clottey, supra*, where the court explained:

> **[934]** Thus, in a multi-complainant case where the inter-count similar act evidence supports a pattern of sexual behavior, the use of the similar act evidence may assist in dispelling reasonable doubt on some counts. However, that is not the case where, as here, the proposed similar act evidence is more suggestive of an entirely innocent explanation.

[169] Dr. Mohammed argues that the remaining elements of the charges which do not pertain to the patient examinations can hardly be seen as so persuasively similar to draw any inference other than general propensity. On that basis, there is little probative value in hearing the evidence of Patient #1 and Patient #2 as similar fact evidence, yet the prejudicial impact on Dr. Mohammed would be significant. As in *Clottey*, there is little, if anything, to support a suggestion of impropriety other than the complainants' subjective belief.

[170] We note the following similarities between the evidence of Patient #1 and Patient #2:

(a) Conduct of stethoscope examinations—Dr. Mohammed standing over the patient who is seated in a chair and putting the stethoscope down the patient's shirt;

(b) Inappropriate touching—of Patient #2 on her arm, shoulder, and shin and of Patient #1 on the hip, buttocks and waist;

(c) Inappropriate personal conversation—asking Patient #2 if he could see her at work, saying he had been thinking about her, asking if she was happy to see him; asking Patient #1 about her husband before "scooping" her into his body and blocking her exit from the examining room; and

(d) In general, progressive advances.

k) Analysis of Credibility and Reliability

[171] We begin with a consideration of Dr. Mohammed's testimony. There is unchallenged independent support for Dr. Mohammed's testimony with respect to the allegations of N.R., to the extent that Dr. Mohammed never wore a wedding ring and that the light in the filing room was always on during office hours. We therefore accept his testimony in this regard.

[172] The only independent memory that Dr. Mohammed testified to regarding either complainant was of Patient #2 discussing her vacation and some vague memory of discussing where she worked. Given the state of upset that both women testified to at the time of their last attendances on Dr. Mohammed, it is difficult to accept Dr. Mohammed's assertion of lack of memory. While a lack of memory of a routine, appropriate interaction is perhaps not surprising given a patient load of somewhere between 12,000 and 15,000, it would be surprising if he did not recall patients leaving his office in the state of upset they described. And a lack of memory of events makes the absence of proper and complete recording of physical examination findings in this case all the more critical.

[173] Dr. Mohammed's testimony was primarily limited to a discussion of his usual practice and to the contents of his clinical notes, in this case his letters to referring physicians. This is where his position becomes particularly problematic. With both Patient #1 and Patient #2, his examination of the breast area was not recorded. While it is true that he is not charged with poor record-keeping practices, absent an independent memory of events, his records are of particular importance. Yet here, they are lacking in several important respects, the most important of which are that his records do not even show the fact of, much less the results of, physical examinations. If he truly felt it was medically necessary to conduct such examinations, then it follows that it would be necessary to report that they had occurred, and the results. Otherwise, it would be impossible for him or any other physician reading his notes to be aware of the range of results, even if normal, that might indicate trends.

[174] Dr. Mohammed's lack of complete records, coupled with the absence of independent recollection of events, leaves him without proper independent reference points with which to defend his conduct or to support his assertion that his conduct was appropriate, even if his examinations were medically necessary – the latter which we find to have probably been the case. However, the absence of such records, coupled with a failure to seek meaningful permission of the patients and explain what he was doing and why; and failure to provide either complainant with the results of his examinations, properly lead to an inference that there was an improper motive behind examinations that in other circumstances may have been perfectly in keeping with the standards of an endocrinologist.

[175] Patient #1's personal history form showed that she was a single parent of two children. Patient #2's personal history form showed her marital status as single and listed a female family member as next of kin. Dr. Mohammed was aware of a strong desire on the part of Patient #2 to become pregnant. These factors could lead a physician with ulterior motives to assume a certain vulnerability on the part of both patients.

[176] We find Dr. Mohammed's explanation for not recording the fact or results of physical examinations of Patient #1 and Patient #2 to be troubling and leading to an inference that there were reasons for these examinations that were more than therapeutic in nature. On top of this, Dr. Mohammed's evidence lacked believability. He appeared to be attempting to say things he felt would be persuasive to the Committee.

[177] There is also a lack of consistency in Dr. Mohammed's version of events surrounding Patient #2. She was clear in her testimony that Dr. Mohammed told her he was thinking of her and asked if she was happy to see him. In direct examination Dr. Mohammed stated he would never have asked that: "I don't say that, no reason to say that, can't justify it." However, on cross-examination, he had to agree that when he replied to the College notification of the complaint, he stated: "I do not recall saying that but do not have any reason to say I did not."

[178] We now turn to an analysis of the complainants' testimony. In both cases, we find that their evidence was straightforward, without embellishment. Unlike Dr. Mohammed, who had a background of tens of thousands of stethoscope examinations and appointments, Patient #1 and Patient #2 had only a few appointments with him, the details of which clearly stuck with them. When given an opportunity to exaggerate Dr. Mohammed's conduct, they did not do so and were instead even-handed. It was clear that neither felt she had anything to be gained by this process. To the contrary, each testified to hardships they have endured because of the

complaints. There was no evidence or suggestion of collusion. Neither was challenged on their motivation to come forward.

[179] Patient #1 was not shaken in cross-examination on the central issues of charge #1. Her description of the stethoscope examinations was consistent internally and with the manner in which Dr. Mohammed agreed that he likely would have performed them. She provided clear evidence that at the end of the August 18, 2016 appointment Dr. Mohammed blocked the door, put his arm around her waist/hip and pulled her body into his. Dr. Mohammed flatly denied this but did agree on cross-examination that he had no memory of leaving the examination room with Patient #1 and testified that he sometimes touched patients on their upper back or shoulders when leaving examination rooms until 2016, when he learned this was not acceptable here. She also testified to something brushing against her buttock area as she was leaving. While she did not see his hand, it is difficult to conceive of what else would have brushed against her. We find that the Dr. Mohammed probably touched her buttocks with his hand.

[180] The appointment card[65] supports Patient #1's evidence. Dr. Mohammed's consultation note,[66] completed before they left the examination room, stated follow-up within 6 months. The appointment card noted an appointment in 3 months. We do not doubt Dr. Mohammed's evidence that he was away on vacation during the time frame 6 months after the August 18, 2016 appointment, but it is more plausible that Ms. Craig—who testified that Dr. Mohammed always tells her the time frame for follow-up—would have booked the follow-up for 5 months or 6.5 months, to avoid the vacation time. The appointment card provides objective support for Patient #1's account of what occurred while she was leaving the examination room: she testified that after Dr. Mohammed blocked the door, pulled her against him, and started at her, he said to her that "I can see you in three months – would you like that? The inconsistency between the clinical entry and the appointment confirms Patient #1's evidence.

[181] Patient #1 gave evidence, corroborated by Ms. B, of considerable emotional upset upon leaving Dr. Mohammed's office on August 18, 2016. We contrast this against the evidence of Dr. Mohammed, that he had not given her bad news or anything that would have caused her to be upset.

[182] We also note the significant fact that despite the difficulty in getting in to see an endocrinologist in Regina, Patient #1 never returned to Dr. Mohammed after the August 18, 2016 appointment.

[183] Turning to Patient #2, we note that she was fair in her evidence that she felt her first appointment with Dr. Mohammed was appropriate. She testified that the amount of touching increased on the second visit and recalled that she was wearing a long-sleeved shirt, making it less likely that this touching was part of an examination. She also recalled that on that attendance Dr. Mohammed put the stethoscope up her shirt from the bottom.

[184] Patient #2 testified that the examination conducted by the Jursi on June 4, 2016 seemed appropriate. On the August 4, 2016 visit, she recalled being called into the room by Dr.

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[65] Ex. 3, Tab 5, p. 11

[66] Ex. 3, Tab 4, p. 9

Mohammed. He denied that this was possible. In any event, she recalls wearing a dress that day that had straps and a slit on the leg. She recalled Dr. Mohammed placing his left hand on her shoulder and his right hand on her shin. She also recalled him touching her forearm and hand. She was adamant that he was not looking at the body parts he touched, and was simply resting his hands there, as opposed to kneading, prodding, or conducting any sort of examination.

[185] Patient #2 was clear in her testimony that Dr. Mohammed told her he was thinking about her and asked if she was happy to see him. We contrast this against Dr. Mohammed's testimony in this regard, which was inconsistent and contradictory. His explanation that he frequently asks his receptionist about patients, even while he was on holidays, in the context of his thousands of patients, lacks plausibility.

[186] Patient #2 was equally clear in her evidence with respect to Dr. Mohammed's request to see her at her work. She had a specific memory of their earlier discussion about her work with [redacted] and the location of its office. Dr. Mohammed denied this discussion and explained that he assumed she was a [redacted] at the [redacted] across the parking lot. This explanation lacks plausibility. There would be no reason for him to ask to see her if she worked at [redacted], which he frequented and was entitled to continue to frequent, without her permission. We prefer Patient #2's evidence, given that she has been consistent throughout and has a more plausible reason to recall the details, given the few appointments she had with Dr. Mohammed, compared to the thousands of patients seen by Dr. Mohammed and his lack of supportive records or independent recollection of many of the facts.

[187] Finally, Patient #2 and Ms. M confirmed that Patient #2 was very upset upon returning to work immediately after her August 4, 2016 appointment. Dr. Mohammed testified that she was not upset when she left, and that he had not given her bad news or anything that would have caused her to be upset. While there may have been some room for misinterpretation of Dr. Mohammed's physical examination, particularly had the subsequent conversations not occurred, those conversations only served to confirm Patient #2's discomfort with the totality of his interactions with her. Like Patient #1, she testified that she never returned to see Dr. Mohammed, despite ongoing need for the services of an Endocrinologist.

[188] Both patients recalled the events occurring during their interactions with Dr. Mohammed that had stuck with them as being inappropriate or unusual.

[189] Dr. Mohammed stated that he did nothing wrong and that neither complainant was upset on leaving his office after their last appointments. If this version is correct, one would have to conclude that both women lied or created an inaccurate memory of what occurred.

[190] We conclude that inter-charge similar fact evidence is admissible to assist in rebutting Dr. Mohammed's defence of misinterpretation, misunderstanding, or inadvertence.

[191] The commonalities in the evidence of the two complainants, are:

- They were close in time;
- They both involved suspicious stethoscope examinations and touching, generally without the patient's permission;
- The examinations were not recorded and their results were not reported to the patients;

- Questioning was increasingly inappropriate culminating in more aggressive behavior at the last appointment—in one case physically barricading the patient in the examination room and groping her, and in the other asking if he could visit the patient at her place of work.

[192] These all are clearly inappropriate personal advances to a patient. In *Peirovy*, the Court clarified that the party applying to introduce similar fact evidence does not have to be in a position to provide specific similarities. The evidence in this case reveals that there has been no colloboration or collusion between the complainants and that they are not likely to be making false allegations that just happen to have similar features.

[193] The similar fact evidence in this case is relevant to the following issues:

- Whether the acts occurred as described by the complainants;
- Dr. Mohammed's intention; and
- Rebuttal of an anticipated defence of inadvertence or misunderstanding.

[194] The probative value of these similar acts outweighs the potential prejudice to Dr. Mohammed. Given that there is a Committee rather than a jury, it is less likely that the evidence will be used to support a finding based on an inference of bad character, as opposed to proof of the alleged acts. In addition, "reasoning prejudice" is not a significant risk here, as the Committee is certainly mindful of the issue and will not be unduly distracted by it.

[195] We also note that in the case of the final attendances on Dr. Mohammed by both complainants, the consultation letters prepared by Dr. Mohammed did not detail the result of any chest examination.[67] As noted in the records of N.R. and confirmed by Dr. Mohammed in cross-examination, Dr. Mohammed did sometimes record the results of a chest examination even when normal.[68] This creates an important inconsistency in his testimony. It is difficult to place much weight on his reliance on "standard practice" given that he does not have an invariable practice in conducting or recording the results of stethoscope examinations:

- He sometimes listens over clothing, sometimes under clothing;
- He sometimes asks the patient to lean forward, sometimes not;
- He sometimes puts his hand with the stethoscope down the patients' shirt, and sometimes drops it down inside, keeping his hand on the outside;
- He puts the stethoscope in one to three places, and occasionally in the mitral area;
- Infrequently he would approach from under the shirt when conducting a chest auscultation (as confirmed by Patient #2's evidence).

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[67] Ex. C3, Tab 2, p. 4; Tab 4, p. 9, Tab 13, p. 27, Tab 21, p. 14; and Tab 23, p.44.

[68] Ex. C3, Tab 15, p. 32 and Tab 15, p. 35.

[196] Where the evidence conflicts, we prefer the testimony of the complainants to that of Dr. Mohammed. The allegations of each complainant do support the inference that Dr. Mohammed made inappropriate progressive advances to Patient #1 and Patient #2.

[197] The evidence also establishes a pattern of Dr. Mohammed misusing his position as a doctor to make inappropriate personal advances to the other complainant. The evidence shows more than a mere propensity, based upon bad character. It advances the probability that Dr. Mohammed did what the complainants allege and that his actions were not accidental or misunderstood. The cogency is derived from the objective improbability of the events occurring coincidentally.

[198] The College has satisfied us on a balance of probabilities that the probative value of the evidence outweighs its potential prejudice and thereby justifies its reception. The evidence of each complainant meets the test for similar fact evidence, particularly given what we find was Dr. Mohammed's pattern of approaching vulnerable female patients. Further, although the ultimate escalating incident in each case differed in their particularities, the commonalties are that he attempted to interest each in a personal relationship. We conclude that this inter-charge similar fact evidence, while representing only pieces of the totality of the evidence, assists the Committee in drawing an inference that Dr. Mohammed committed the allegations charged.

[199] The evidence on each allegation may be admitted as evidence on the other allegation. The existence of each fact separately increases the likelihood of the other facts having occurred.

l) ***Conclusions* of *Fact***

[200] After careful deliberation, we find it probable, based on clear, cogent, and convincing evidence, that the following occurred:

Patient #1

- When Patient #1 attended on Dr. Mohammed on July 19, 2016, without warning or discussion, he pulled her shirt out, placed his hand, with a stethoscope, down the front of her shirt in close proximity to her breast and asked her to lean forward while he was standing in front of her.
- On August 18, 2016, Dr. Mohammed advised Patient #1 that he would conduct a thyroid examination on her. He brushed her hair from her neck and said he wanted to listen to her chest. He placed his hand, with a stethoscope, down the front of her shirt, on or close to her breast and asked her to lean forward while he stood in front of her.
- Dr. Mohammed did not obtain permission from Patient #1 to the stethoscope examination or examinations; did not explain what he was doing and why; and did not explain the results of these examinations.
- On August 18, 2016, Dr. Mohammed asked Patient #1 whether she had a husband or boyfriend, what she did for work, whether she had children and three times asked her if she lived in the city. After the examination, as she was leaving the examination room, Dr. Mohammed stood in front of the door to the room with his foot against the

door, placed his arm around her lower back and hip, scooped her in towards him and touched her buttocks with his hand.[69]

Patient #2

- On May 3, 2016, Dr. Mohammed touched Patient #2 more than on her previous appointment, including a longer-than-usual handshake and touching on her arm that was different than the first appointment. He touched her arm without looking at her skin. He did not poke or pinch the arm, but rather rested his hand on it. Without warning, he put the stethoscope with his hand under her shirt but not so far as her breast.
- On August 4, 2016, Dr. Mohammed repeatedly and for extended periods of time, placed his hand on Patient #2's bare forearm, shoulder and shin, all without looking at the skin he was touching and without moving his hand. He inserted his stethoscope under her dress from the top of her dress, placed the stethoscope slightly under her bra and onto her breast, slightly touching the areola;
- Dr. Mohammed did not obtain permission from Patient #2 to the stethoscope examination or physical examinations. He did not explain what he was doing and why, or explain the results; nor did he record these examinations;
- Dr. Mohammed engaged in personal conversations with Patient #2 including telling her he had been thinking about her and asking her if she missed him and if he could visit her at her place of work.

m) Weighing the Expert Evidence

[201] Dr. McKague, called on behalf of the College, was a most impressive witness. She presented her opinion evidence on the standards of the medical profession regarding physical examination, including a stethoscope examination, and maintaining appropriate professional boundaries, in an unbiased, even-handed, and reasonable manner. She provided evidence in support of Dr. Mohammed when she felt that was appropriate. Dr. McKague testified that the relevant standards of the profession, which apply equally to all physicians including endocrinologists, are as follows:

- In performing a physical examination, the physician must treat the patient with respect and be sensitive to modesty. The physician must provide a brief explanation of the intended exam and its purpose; ensure consent has been obtained; advise the patient briefly of the findings of the examination; and record pertinent positive and negative findings;
- In performing a stethoscope examination, the physician must obtain permission to conduct the examination; take steps to ensure patient comfort and modesty; and explain the findings to the patient. Because breasts can be a sexualized body part, Dr.

[69] We do not have sufficient information to find that Dr. Mohammed looked at Patient #1's buttocks.

McKague states that the physician performing a chest auscultation on a female patient must be mindful to ensure proper draping and explanation;

- In relation to maintaining professional boundaries, a physician must keep in mind that the intention of the visit is to benefit patient health; must maintain patient comfort; and be mindful that the patient may be vulnerable.

[202] Interestingly, in cross-examination, Dr. Mohammed agreed that each of these standards apply equally to endocrinologists. On the other hand, Dr. England testified to the effect that endocrinologists have their own unique professional standard of that does not require them to seek permission to examine a patient, even in proximity to sexualized body parts, to explain the examination to the patient or record the findings. She also testified to the effect that an endocrinologist is not required to pay attention to where the stethoscope is landing in a stethoscope examination on or near female breasts. We are unable to accept her evidence in respect of these matters as setting out the standards of the profession for endocrinologists. For the reasons expressed below, the Committee does not ascribe much weight to Dr. England's evidence.

[203] We do accept Dr. England's opinion to the following extent:

- the stethoscope examinations were medically necessary;
- the usual requirements to perform a cardiac auscultation are not the applicable standard of practice for endocrinologists: endocrinologists are not required to listen to all four listening posts; and
- asking the patient to lean forward during a stethoscope examination is within an acceptable standard for an endocrinologist.

[204] We qualify these findings with the observation that they are premised on the motivation behind taking these steps being to benefit the patient, and not the physician.

[205] However, we are unable to accept Dr. England's testimony with respect to aspects of the proper conduct of a stethoscope examination. She was adamant on cross-examination that a physician does not need to be mindful of putting the stethoscope on the patient's areola, and that the physician would not know where the areola is if the patient is clothed. She stated that the physician would put the stethoscope down the patient's shirt and move it around until they found a good place to listen. She denied that the listening posts would provide the best locations and suggested that even the areola might provide the best vantage point at times. We are unable to accept this testimony. Even Dr. Mohammed agreed on cross-examination that it would not be appropriate to place the stethoscope on the areola and that it would not be an appropriate place for listening to heart sounds.

[206] It became increasingly clear during Dr. England's testimony that most of her opinion was based on the assumption that Dr. Mohammed had done everything correctly and appropriately. On several occasions, she strayed from the question posed by Dr. Mohammed's counsel to advise the Committee what Dr. Mohammed "must have done." Her evidence on the areola issue was the ultimate example of this approach. This was further evident in her testimony that if a physician who is assessing a patient's skin does not actually need to look at the skin. Both Dr. McKague and Dr. Mohammed agreed that one would have to look at the skin (particularly in the context of touching the shin for pitting edema) if assessing it. Dr. England

assumed that the touching of the shin was part of a thorough examination. This is despite Dr. Mohammed's confirmation on cross-examination, that he did not recall touching Patient #2's shin on the August 4, 2016 attendance.

[207] We acknowledge that the Committee is not able to use its specialized knowledge to "create" evidence or to fill in gaps in the evidence. To do so would be inconsistent with the the duty of fairness to the physician, who must have an opportunity to know the evidence being submitted and to properly respond.

[208] However, Committee members may use their own specialized knowledge and expertise to critically assess the evidence of both experts, and to determine the appropriate weight to apply to each.[70] We do not doubt Dr. England's considerable diagnostic expertise in her field. However, her testimony raises significant concerns that she may be out of step with current standards in relation to communications, professional boundaries, and record-keeping that apply to all physicians regardless of specialty. And, her views about what is appropriate in the context of stethoscope examinations of female patients in the breast area do not represent the standards of the profession, which we find apply to endocrinologists. Patients attending a specialist are entitled to expect a higher standard of care than that provided by general practitioners, not a lower standard, as Dr. England's testimony implies. In assessing the evidence of the experts, we give substantially more weight to the evidence of Dr. McKague than to that of Dr. England.

n) Do the proven facts amount to unbecoming, improper, unprofessional, or discreditable conduct?

[209] Having established on a balance of probabilities that the acts complained of did occur, the College must establish on a balance of probabilities that those acts constitute unprofessional conduct.

[210] We find Dr. McKague's testimony on these issues persuasive. However, it may be that her evidence is of somewhat more limited use with respect to the Bylaw charges, which relate to the specialty in question and not to the standards of the profession generally. For reasons set out earlier, we focus instead on whether the conduct breaches the general charging provision of the Act.

[211] Regarding the stethoscope examinations, we find that Dr. England's testimony is predicated on an assumption of appropriate intentions on the part of Dr. Mohammed. However, the conversations and culminating incidents described by both Patient #1 and Patient #2 cast serious doubts on whether Dr. Mohammed intended the stethoscope examinations for the benefit of his patients, or instead his own. It is thus difficult to view those culminating incidents in isolation from the stethoscope examinations and the touching that preceded them. If intended for proper purposes, we would accept Dr. England's testimony that the stethoscope examinations in question would be considered medically necessary by an endocrinologist investigating thyroid issues in these circumstances. The same could be said for the brushing away of the hair and the touching of the shoulders, even though in this case there was no evidence to suggest that either complainant needed steadying. It may even be the case,

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[70] *Ali v CPSS*, 2016 SKQB 42, paragraphs 31-34

considering Dr. England's testimony, that an endocrinologist might not be required to look at the areas of skin he was touching. However, we find that the touching of the shin, hands, and forearms were not part of a physical examination, given the evidence of the two complainants—which we accept—that Dr. Mohammed did not knead, prod or probe the skin, as would be expected if the touching was part of a physical examination, but simply rested his hand on these body parts.

[212] Dr. Mohammed's conduct fell below the standard of his profession in regards to both complainants by failing to:

- respect the vulnerability of the patients;
- respect their modesty;
- obtain their permission before the touching occurred;
- explain what he was doing and why;
- explain the results of the examinations; or
- record the examinations in the patients' charts;

[213] Regarding Patient #2 and Dr. Mohammed's placement of the stethoscope over the areola, we find that even if this examination could be defended on the basis of being medically indicated, it was done inappropriately and for an improper purpose.[71] It was distressing to Patient #2 and conducted in a manner that fell below the standards of the profession. A discipline hearing committee is entitled to use its own knowledge of the profession to determine if proved conduct is unprofessional.[72]

[214] There may initially have been some basis for misinterpretation in relation to the stethoscope examinations. However, the two complainants cannot be mistaken on the central points; the "scooping" incident involving Patient #1 and blocking her from exiting the examination room and the culminating incident involving Patient #2 in which Dr. Mohammed told Patient #2 he had been thinking about her, asked her if she had missed him and if he could visit her at her place of work. Quite apart from Bylaw 8.1(2)(a) 8, Dr. Mohammed agreed with Dr. McKague that a woman's breast is a sexualized body part and that a stethoscope examination should be conducted only if medically indicated. While both Drs. Mohammed and England testified that each of the stethoscope examinations was medically indicated, there is some evidence to the contrary. First, there is the issue of record-keeping. Dr. Mohammed does not dispute that his notes do not record the stethoscope examinations. In direct examination, when asked whether he had performed a stethoscope examination during the various appointments, he responded variably: re Patient #1 – "probably" on July 19, 2016; "may have" on August 18, 2016; "most likely yes" on August 4, 2016; re Patient #2 – "most likely" on May 3, 2016, "probably yes" on August 4, 2016; re N.R. – "possibly yes" on April 15, 2015. The fact that he does not consistently record a stethoscope examination, coupled with the fact that

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[71] *CPSS v. Huerto* (1988, DC)

[72] *Huerto v CPSS,* 1994 CanLII 4900 (SK QB)

he clearly does not have an invariable routine in this regard, makes it impossible to confirm whether these examinations were indicated. Further, he did confirm on cross-examination that the standard of the profession would require documenting positive or pertinent negative findings. The notes regarding two of N.R.'s appointments did record stethoscope examinations. However, on the attendances about which Patient #1, Patient #2 and N.R. described questionable stethoscope examinations, those examinations were NOT medically recorded. From this, the panel can draw an inference that the stethoscope examinations were not conducted appropriately in these particular instances. The same can be said about the touching of exposed skin, which, had it been part of a physical examination, was required by standards of the profession to be recorded in the charts.

[215] Even if the stethoscope examinations were not considered in and of themselves to be professional misconduct, cumulatively, we find that they were. In any case, the complainants' evidence is largely unchallenged on the other allegations and the culminating incidents, which we find went beyond the crossing of boundaries and amounted to boundaries violations.

H. CONCLUSION

[216] The evidence in this matter, which we find to be clear, convincing, and cogent, supports a finding that Dr. Mohammed is guilty of unprofessional conduct, pursuant to sub-section 46 (o) of the *Medical Profession Act, 1981* by conduct that we find to be unbecoming, improper, unprofessional or discreditable.

[217] A number of acts involving both Patient #1 and Patient #2 constituted professional misconduct individually and can also be seen as an escalating pattern of unprofessional conduct, consisting of the following:

a. Conducting an examination of the breast area, not recorded;

b. Conducting this examination inappropriately, by failing to:

   i. Take steps to respect the vulnerability and modesty of his patients, by such means as draping or insisting upon the presence of a chaperone;

   ii. Explain to the patients what the examination would entail, to ensure that the patients understood the intention behind the examination;

   iii. Communicate with the patient during the examination in order to ensure their comfort;

   iv. Explain the results of the examination to the patients;

   v. In the case of patient 2, placing the stethoscope over the areola.

c. Engaging in repeat stethoscope examinations for both patients and failing to record the fact or results of them;

d. Failing to record that the repeated (and we find inappropriate) touching of Patient #2's bare forearm, shoulder and shin occurred at all, or as part of a physical examination;

e. Asking increasingly personal questions that were unnecessary and inappropriate to the examinations;

f. The serious "scooping" incident with Patient #1 while preventing her from exiting the examination room and touching her buttocks with his hand while she exited the examination room;

g. Repeated touching of Patient #2's bare forearm, shoulder and shin, simply resting his hand in those spots without doing anything to suggest a medically-indicated exam, or reporting such an examination;

h. Telling Patient #2 he had been thinking of her, asking her if she missed him and if he could visit her #2 at her place of work.

[210] We wish to express our gratitude to counsel for their thorough and helpful submissions.

Dated this 31st day of July 2019

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Daniel Shapiro, Q.C.
Chair, Discipline Hearing Committee

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Dr. Dimitri Louvish

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Dr. Lorne Rabuka

f. The serious "scooping" incident with Patient #1 while preventing her from exiting the examination room and touching her buttocks with his hand while she exited the examination room;

g. Repeated touching of Patient #2's bare forearm, shoulder and shin, simply resting his hand in those spots without doing anything to suggest a medically-indicated exam, or reporting such an examination;

h. Telling Patient #2 he had been thinking of her, asking her if she missed him and if he could visit her #2 at her place of work.

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Dated this 31st day of July 2019

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